State of Minnesota



# HOUSE OF REPRESENTATIVES

**EIGHTY-EIGHTH SESSION**

**H. F. No. 2402**

02/27/2014 Authored by Liebling and Zerwas
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/31/2014 Adoption of Report: Amended and Placed on the General Register
Read Second Time

A bill for an act

relating to state government; making changes to health and human services policy provisions; modifying provisions relating to children and family services, the provision of health services, chemical and mental health services, health-related licensing boards, Department of Health, public health, continuing care, and health care; establishing reporting requirements and grounds for disciplinary action for health professionals; making changes to the medical assistance program; modifying the newborn screening program; regulating the sale and use of tobacco-related and electronic delivery devices; modifying requirements for local boards of health; modifying provisions governing prescription drugs; making changes to provisions governing the Board of Pharmacy; modifying home and community-based services standards; making changes to grant programs; modifying certain penalty fees; requiring studies and reports; amending Minnesota Statutes 2012, sections 62J.497, subdivision 5; 62U.04, subdivision 4, by adding subdivisions; 144.125, subdivisions 3, 4, 5, 8, 9, 10; 144.1501, subdivision 1; 144.4165; 144.565, subdivision 4; 144D.065; 144E.101, subdivision 6; 145.928, by adding a subdivision; 145A.02, subdivisions 5, 15, by adding subdivisions; 145A.03, subdivisions 1, 2, 4, 5, by adding a subdivision; 145A.04, as amended; 145A.05, subdivision 2; 145A.06, subdivisions 2, 5, 6, by adding subdivisions; 145A.07, subdivisions 1, 2; 145A.08; 145A.11, subdivision 2; 145A.131; 148.01, subdivisions 1, 2, by adding a subdivision; 148.105, subdivision 1; 148.6402, subdivision 17; 148.6404; 148.6430; 148.6432, subdivision 1; 148.7802, subdivisions 3, 9; 148.7803, subdivision 1; 148.7805, subdivision 1; 148.7808, subdivisions 1, 4; 148.7812, subdivision 2; 148.7813, by adding a subdivision; 148.7814; 148.995, subdivision 2; 148B.5301, subdivisions 2, 4; 149A.92, by adding a subdivision; 150A.01, subdivision 8a; 150A.06, subdivisions 1, 1a, 1c, 1d, 2, 2a, 2d, 3, 8; 150A.091, subdivision 16; 150A.10; 151.01; 151.06; 151.211; 151.26; 151.34; 151.35; 151.361, subdivision 2; 151.37, as amended; 151.44; 151.58, subdivisions 2, 3, 5; 152.126, as amended; 153.16, subdivisions 1, 2, 3, by adding subdivisions; 214.103, subdivisions 2, 3; 214.12, by adding a subdivision; 214.29; 214.31; 214.32; 214.33, subdivision 3, by adding a subdivision; 245A.02, subdivision 19; 245A.03, subdivision 6a; 245A.155, subdivisions 1, 2, 3; 245A.65, subdivision 2; 253B.092, subdivision 2; 254B.01, by adding a subdivision; 254B.05, subdivision 5; 256B.0654, subdivision 1; 256B.0659, subdivisions 11, 28; 256B.0751, by adding a subdivision; 256B.493, subdivision 1; 256B.5016, subdivision 1; 256B.69, subdivision 16, by adding a subdivision; 256D.01, subdivision 1e; 256G.02, subdivision 6; 256I.03, subdivision 3; 256I.04, subdivision 2a; 260C.157, subdivision 3; 260C.215, subdivisions 4, 6, by adding

a subdivision; 325H.05; 325H.09; 393.01, subdivisions 2, 7; 461.12; 461.18; 461.19; 609.685; 609.6855; 626.556, subdivision 11c; Minnesota Statutes 2013 Supplement, sections 144.1225, subdivision 2; 144.125, subdivision 7; 144.493, subdivisions 1, 2; 144A.474, subdivision 12; 144A.475, subdivision 3, by adding subdivisions; 145.4716, subdivision 2; 145A.06, subdivision 7; 151.252, by adding a subdivision; 152.02, subdivision 2; 245D.02, by adding a subdivision; 245D.05, subdivisions 1, 1b; 245D.06, subdivision 1; 245D.07, subdivision 2; 245D.071, subdivisions 1, 3, 4, 5; 245D.09, subdivisions 3, 4, 4a, 5; 245D.095, subdivision 3; 245D.22, subdivision 4; 245D.31, subdivisions 3, 4, 5; 245D.33; 254A.035, subdivision 2; 254A.04; 256B.04, subdivision 21; 256B.0659, subdivision 21; 256B.0922, subdivision 1; 256B.4912, subdivision 10; 256B.492; 256B.766; 256B.85, subdivision 12; 260.835, subdivision 2; 626.557, subdivision 9; Laws 2011, First Special Session chapter 9, article 7, section 7; article 9, section 17; Laws 2013, chapter 108, article 7, section 60; proposing coding for new law in Minnesota Statutes, chapters 144; 144D; 150A; 151; 214; 325H; 403; 604A; repealing Minnesota Statutes 2012, sections 144.125, subdivision 6; 145A.02, subdivision 2; 145A.03, subdivisions 3, 6; 145A.09, subdivisions 1, 2, 3, 4, 5, 7; 145A.10, subdivisions 1, 2, 3, 4, 5a, 7, 9, 10; 145A.12, subdivisions 1, 2, 7; 148.01, subdivision 3; 148.7808, subdivision 2; 148.7813; 214.28; 214.36; 214.37; 256.01, subdivision 32; 325H.06; 325H.08; Minnesota Statutes 2013 Supplement, sections 148.6440; 245D.071, subdivision 2; Laws 2011, First Special Session chapter 9, article 6, section 95, subdivisions 1, 2, 3, 4; Minnesota Rules, parts 2500.0100, subparts 3, 4b, 9b; 2500.4000; 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; 9500.1456; 9505.5300; 9505.5305; 9505.5310; 9505.5315; 9505.5325; 9525.1580.

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

## ARTICLE 1

## CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2012, section 245A.02, subdivision 19, is amended to read:

Subd. 19. **Family day care and group family day care child age classifications.** (a) For the purposes of family day care and group family day care licensing under this chapter, the following terms have the meanings given them in this subdivision.

(b) "Newborn" means a child between birth and six weeks old.

(c) "Infant" means a child who is at least six weeks old but less than 12 months old.

(d) "Toddler" means a child who is at least 12 months old but less than 24 months old, except that for purposes of specialized infant and toddler family and group family day care, "toddler" means a child who is at least 12 months old but less than 30 months old.

(e) "Preschooler" means a child who is at least 24 months old up to ~~the~~ school age ~~of being eligible to enter kindergarten within the next four months~~.

(f) "School age" means a child who is at least ~~of sufficient age to have attended the first day of kindergarten, or is eligible to enter kindergarten within the next four months~~ five years of age, but is younger than 11 years of age.

Sec. 2. Minnesota Statutes 2012, section 260C.215, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

(1) provide practice guidance to responsible social services agencies and child-placing agencies that reflect federal and state laws and policy direction on placement of children;

(2) develop criteria for determining whether a prospective adoptive or foster family has the ability to understand and validate the child's cultural background;

(3) provide a standardized training curriculum for adoption and foster care workers and administrators who work with children. Training must address the following objectives:

(i) developing and maintaining sensitivity to all cultures;

(ii) assessing values and their cultural implications;

(iii) making individualized placement decisions that advance the best interests of a particular child under section 260C.212, subdivision 2; and

(iv) issues related to cross-cultural placement;

(4) provide a training curriculum for all prospective adoptive and foster families that prepares them to care for the needs of adoptive and foster children taking into consideration the needs of children outlined in section 260C.212, subdivision 2, paragraph (b);

(5) develop and provide to agencies a home study format to assess the capacities and needs of prospective adoptive and foster families. The format must address problem-solving skills; parenting skills; evaluate the degree to which the prospective family has the ability to understand and validate the child's cultural background, and other issues needed to provide sufficient information for agencies to make an individualized placement decision consistent with section 260C.212, subdivision 2. For a study of a prospective foster parent, the format must also address the capacity of the prospective foster parent to provide a safe, healthy, smoke-free home environment. If a prospective adoptive parent has also been a foster parent, any update necessary to a home study for the purpose of adoption may be completed by the licensing authority responsible for the foster parent's license. If a prospective adoptive parent with an approved adoptive home study also applies for a foster care license, the license application may be made with the same agency which provided the adoptive home study; and

(6) consult with representatives reflecting diverse populations from the councils established under sections 3.922, 3.9223, 3.9225, and 3.9226, and other state, local, and community organizations.

Sec. 3. Minnesota Statutes 2012, section 260C.215, subdivision 6, is amended to read:

Subd. 6. **Duties of child-placing agencies.** (a) Each authorized child-placing agency must:

(1) develop and follow procedures for implementing the requirements of section 260C.212, subdivision 2, and the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923;

(2) have a written plan for recruiting adoptive and foster families that reflect the ethnic and racial diversity of children who are in need of foster and adoptive homes. The plan must include:

(i) strategies for using existing resources in diverse communities;

(ii) use of diverse outreach staff wherever possible;

(iii) use of diverse foster homes for placements after birth and before adoption; and

(iv) other techniques as appropriate;

(3) have a written plan for training adoptive and foster families;

(4) have a written plan for employing staff in adoption and foster care who have the capacity to assess the foster and adoptive parents' ability to understand and validate a child's cultural and meet the child's individual needs, and to advance the best interests of the child, as required in section 260C.212, subdivision 2. The plan must include staffing goals and objectives;

(5) ensure that adoption and foster care workers attend training offered or approved by the Department of Human Services regarding cultural diversity and the needs of special needs children; ~~and~~

(6) develop and implement procedures for implementing the requirements of the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act~~.~~; and

(7) ensure that children in foster care are protected from the effects of secondhand smoke and that licensed foster homes maintain a smoke-free environment in compliance with subdivision 9.

(b) In determining the suitability of a proposed placement of an Indian child, the standards to be applied must be the prevailing social and cultural standards of the Indian child's community, and the agency shall defer to tribal judgment as to suitability of a particular home when the tribe has intervened pursuant to the Indian Child Welfare Act.

Sec. 4. Minnesota Statutes 2012, section 260C.215, is amended by adding a subdivision to read:

Subd. 9. **Preventing exposure to secondhand smoke for children in foster care.** (a) A child in foster care shall not be exposed to any type of secondhand smoke in the following settings:

(1) a licensed foster home or any enclosed space connected to the home, including a garage, porch, deck, or similar space; or

(2) a motor vehicle while a foster child is transported.

(b) Smoking in outdoor areas on the premises of the home is permitted, except when a foster child is present and exposed to secondhand smoke.

(c) The home study required in subdivision 4, clause (5), must include a plan to maintain a smoke-free environment for foster children.

(d) If a foster parent fails to provide a smoke-free environment for a foster child, the child-placing agency must ask the foster parent to comply with a plan that includes training on the health risks of exposure to secondhand smoke. If the agency determines that the foster parent is unable to provide a smoke-free environment and that the home environment constitutes a health risk to a foster child, the agency must reassess whether the placement is based on the child's best interests consistent with section 260C.212, subdivision 2.

(e) Nothing in this subdivision shall delay the placement of a child with a relative, consistent with section 245A.035, unless the relative is unable to provide for the immediate health needs of the individual child.

(f) If a child's best interests would most effectively be served by placement in a home which will not meet the requirements of paragraph (a), the failure to meet the requirements of paragraph (a) shall not be a cause to deny placement in that home.

(g) Nothing in this subdivision shall be interpreted to interfere, conflict with, or be a basis for denying placement pursuant to the provisions of the federal Indian Child Welfare Act or Minnesota Indian Family Preservation Act.

(h) Nothing in this subdivision shall be interpreted to interfere with traditional or spiritual Native American or religious ceremonies involving the use of tobacco.

Sec. 5. Minnesota Statutes 2012, section 626.556, subdivision 11c, is amended to read:

Subd. 11c. **Welfare, court services agency, and school records maintained.** Notwithstanding sections 138.163 and 138.17, records maintained or records derived from reports of abuse by local welfare agencies, agencies responsible for assessing or investigating the report, court services agencies, or schools under this section shall be destroyed as provided in paragraphs (a) to (d) by the responsible authority.

(a) For family assessment cases and cases where an investigation results in no determination of maltreatment or the need for child protective services, the assessment or investigation records must be maintained for a period of four years. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future risk and safety assessments.

(b) All records relating to reports which, upon investigation, indicate either maltreatment or a need for child protective services shall be maintained for at least ten years after the date of the final entry in the case record.

(c) All records regarding a report of maltreatment, including any notification of intent to interview which was received by a school under subdivision 10, paragraph (d), shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(d) Private or confidential data released to a court services agency under subdivision 10h must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

(e) For reports alleging child maltreatment that were not accepted for assessment or investigation, counties shall maintain sufficient information to identify repeat reports alleging maltreatment of the same child or children for 365 days from the date the report was screened out. The Department of Human Services shall specify to the counties the minimum information needed to accomplish this purpose. Counties shall enter this data into the state social services information system.

Sec. 6. **MINNESOTA TANF EXPENDITURES TASK FORCE.**

Subdivision 1. **Establishment.** The Minnesota TANF Expenditures Task Force is established to analyze past temporary assistance for needy families (TANF) expenditures and make recommendations as to which, if any, programs currently receiving TANF funding should be funded by the general fund so that a greater portion of TANF funds can go directly to Minnesota families receiving assistance through the Minnesota family investment program under Minnesota Statutes, chapter 256J.

Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of the following members who serve at the pleasure of their appointing authority:

(1) one representative of the Department of Human Services appointed by the commissioner of human services;

(2) one representative of the Department of Management and Budget appointed by the commissioner of management and budget;

(3) one representative of the Department of Health appointed by the commissioner of health;

(4) one representative of the Local Public Health Association of Minnesota;

(5) two representatives of county government appointed by the Association of Minnesota Counties, one representing counties in the seven-county metropolitan area and one representing all other counties;

(6) one representative of the Minnesota Legal Services Coalition;

(7) one representative of the Children's Defense Fund of Minnesota;

(8) one representative of the Minnesota Coalition for the Homeless;

(9) one representative of the Welfare Rights Coalition;

(10) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader; and

(11) two members of the senate, including one member of the minority party, appointed according to the rules of the senate.

(b) Notwithstanding Minnesota Statutes, section 15.059, members of the task force shall serve without compensation or reimbursement of expenses.

(c) The commissioner of human services must convene the first meeting of the Minnesota TANF Expenditures Task Force by July 31, 2014. The task force must meet at least quarterly.

(d) Staffing and technical assistance shall be provided within available resources by the Department of Human Services, children and family services division.

Subd. 3. **Duties.** (a) The task force must report on past expenditures of the TANF block grant, including a determination of whether or not programs for which TANF funds have been appropriated meet the purposes of the TANF program as defined under Code of Federal Regulations, title 45, section 260.20, and make recommendations as to which, if any, programs currently receiving TANF funds should be funded by the general fund. In making recommendations on program funding sources, the task force shall consider the following:

(1) the original purpose of the TANF block grant under Code of Federal Regulations, title 45, section 260.20;

(2) potential overlap of the population eligible for the Minnesota family investment program cash grant and the other programs currently receiving TANF funds;

(3) the ability for TANF funds, as appropriated under current law, to effectively help the lowest-income Minnesotans out of poverty;

(4) the impact of past expenditures on families who may be eligible for assistance through TANF;

(5) the ability of TANF funds to support effective parenting and optimal brain development in children under five years old; and

(6) the role of noncash assistance expenditures in maintaining compliance with federal law.

(b) In preparing the recommendations under paragraph (a), the task force shall consult with appropriate Department of Human Services information technology staff regarding implementation of the recommendations.

Subd. 4. **Report.** (a) The task force must submit an initial report by November 30, 2014, on past expenditures of the TANF block grant in Minnesota to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(b) The task force must submit a final report by February 1, 2015, analyzing past TANF expenditures and making recommendations as to which programs, if any, currently receiving TANF funding should be funded by the general fund, including any phase-in period and draft legislation necessary for implementation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 5. **Expiration.** This section expires March 1, 2015, or upon submission of the final report required under subdivision 4, whichever is earlier.

Sec. 7. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the term "guardianship assistance" to "Northstar kinship assistance" wherever it appears in Minnesota Statutes and Minnesota Rules to refer to the program components related to Northstar Care for Children under Minnesota Statutes, chapter 256N.

## ARTICLE 2

## PROVISION OF HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 144E.101, subdivision 6, is amended to read:

Subd. 6. **Basic life support.** (a) Except as provided in paragraphs (e) and (f), a basic life-support ambulance shall be staffed by at least two EMTs, one of whom must accompany the patient and provide a level of care so as to ensure that:

(1) life-threatening situations and potentially serious injuries are recognized;

(2) patients are protected from additional hazards;

(3) basic treatment to reduce the seriousness of emergency situations is administered; and

(4) patients are transported to an appropriate medical facility for treatment.

(b) A basic life-support service shall provide basic airway management.

(c) A basic life-support service shall provide automatic defibrillation.

(d) A basic life-support service licensee's medical director may authorize ambulance service personnel to perform intravenous infusion and use equipment that is within the licensure level of the ambulance service, including administration of an opiate antagonist. Ambulance service personnel must be properly trained. Documentation of authorization for use, guidelines for use, continuing education, and skill verification must be maintained in the licensee's files.

(e) Upon application from an ambulance service that includes evidence demonstrating hardship, the board may grant a variance from the staff requirements in paragraph (a) and may authorize a basic life-support ambulance to be staffed by one EMT and one registered emergency medical responder driver for all emergency ambulance calls and interfacility transfers. The variance shall apply to basic life-support ambulances operated by the ambulance service until the ambulance service renews its license. When a variance expires, an ambulance service may apply for a new variance under this paragraph. For purposes of this paragraph, "ambulance service" means either an ambulance service whose primary service area is mainly located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 1,000.

(f) After an initial emergency ambulance call, each subsequent emergency ambulance response, until the initial ambulance is again available, and interfacility transfers, may be staffed by one registered emergency medical responder driver and an EMT. The EMT must accompany the patient and provide the level of care required in paragraph (a). This paragraph applies only to an ambulance service whose primary service area is mainly located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance based in a community with a population of less than 1,000 persons.

Sec. 2. **[150A.055] ADMINISTRATION OF INFLUENZA IMMUNIZATIONS.**

Subdivision 1. **Practice of dentistry.** A person licensed to practice dentistry under sections 150A.01 to 150A.14 shall be deemed to be practicing dentistry while participating in the administration of an influenza vaccination.

Subd. 2. **Qualified dentists.** (a) The influenza immunization shall be administered only to patients 19 years of age and older and only by licensed dentists who:

(1) have immediate access to emergency response equipment, including but not limited to oxygen administration equipment, epinephrine, and other allergic reaction response equipment; and

(2) are trained in or have successfully completed a program approved by the Minnesota Board of Dentistry, specifically for the administration of immunizations. The training or program must include:

(i) educational material on the disease of influenza and vaccination as prevention of the disease;

(ii) contraindications and precautions;

(iii) intramuscular administration;

(iv) communication of risk and benefits of influenza vaccination and legal requirements involved;

(v) reporting of adverse events;

(vi) documentation required by federal law; and

(vii) storage and handling of vaccines.

(b) Any dentist giving influenza vaccinations under this section shall comply with guidelines established by the federal Advisory Committee on Immunization Practices relating to vaccines and immunizations, which includes, but is not limited to, vaccine storage and handling, vaccine administration and documentation, and vaccine contraindications and precautions.

Subd. 3. **Coordination of care.** After a dentist qualified under subdivision 2 has administered an influenza vaccine to a patient, the dentist shall report the administration of the immunization to the Minnesota Immunization Information Connection or otherwise notify the patient's primary physician or clinic of the administration of the immunization.

**EFFECTIVE DATE.** This section is effective January 1, 2015, and applies to influenza immunizations performed on or after that date.

Sec. 3. Minnesota Statutes 2012, section 151.37, is amended by adding a subdivision to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant authorized to prescribe drugs pursuant to section 147A.18, may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d); and

(3) staff of community-based health disease prevention or social service programs.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

Sec. 4. **[151.71] MAXIMUM ALLOWABLE COST PRICING.**

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

(b) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(c) "Pharmacy benefit manager" means an entity doing business in this state that contracts to administer or manage prescription drug benefits on behalf of any health plan company that provides prescription drug benefits to residents of this state.

Subd. 2. **Pharmacy benefit manager contracts with pharmacies; maximum allowable cost pricing.** (a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager a current list of the sources used to determine maximum allowable cost pricing. The pharmacy benefit manager shall update the pricing information at least every seven business days and provide a means by which contracted pharmacies may promptly review current prices in an electronic, print, or telephonic format within one business day at no cost to the pharmacy. A pharmacy benefit manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with changes in the marketplace.

(b) In order to place a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that the drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(c) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:

(1) a 15 business day limit on the right to appeal following the initial claim;

(2) a requirement that the appeal be investigated and resolved within seven business days after the appeal; and

(3) a requirement that a pharmacy benefit manager provide a reason for any appeal denial and identify the national drug code of a drug that may be purchased by the pharmacy at a price at or below the maximum allowable cost price as determined by the pharmacy benefit manager.

(d) If the appeal is upheld, the pharmacy benefit manager shall make an adjustment to the maximum allowable cost price no later than one business day after the date of determination. The pharmacy benefit manager shall make the price adjustment applicable to all similarly situated network pharmacy providers as defined by the plan sponsor.

**EFFECTIVE DATE.** This section is effective January 1, 2015.

Sec. 5. Minnesota Statutes 2012, section 152.126, as amended by Laws 2013, chapter 113, article 3, section 3, is amended to read:

**152.126 ~~CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM~~ PRESCRIPTION MONITORING PROGRAM.**

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

~~(a)~~ (b) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

~~(b)~~ (c) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to ~~5~~ 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12. For the purposes of this section, controlled substances includes tramadol and butalbital.

~~(c)~~ (d) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

~~(d)~~ (e) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

~~(e)~~ (f) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1 or 2.

~~(f)~~ (g) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or interfere with the legitimate prescribing of controlled substances for pain. No prescriber shall be subject to disciplinary action by a health-related licensing board for prescribing a controlled substance according to the provisions of section 152.125.

Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish by January 1, 2010, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, operation, and maintenance of the electronic reporting system.

Subd. 3. **Prescription ~~Electronic Reporting~~ Monitoring Program Advisory ~~Committee~~ Task Force.** (a) The board ~~shall convene~~ shall appoint an advisory ~~committee. The committee must include~~ task force consisting of at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a professional nursing association;

(7) a professional dental association;

(8) a consumer privacy or security advocate; and

(9) a consumer or patient rights organization.

(b) The advisory ~~committee~~ task force shall advise the board on the development and operation of the ~~electronic reporting system~~ prescription monitoring program, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

(c) The task force is governed by section 15.059. Notwithstanding section 15.059, subdivision 5, the task force shall not expire.

Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the following data to the board or its designated vendor~~, subject to the notice required under paragraph (d)~~:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) prescription number;

(6) name of the patient for whom the prescription was written;

(7) address of the patient for whom the prescription was written;

(8) date of birth of the patient for whom the prescription was written;

(9) date the prescription was written;

(10) date the prescription was filled;

(11) name and strength of the controlled substance;

(12) quantity of controlled substance prescribed;

(13) quantity of controlled substance dispensed; and

(14) number of days supply.

(b) The dispenser must submit the required information by a procedure and in a format established by the board. The board may allow dispensers to omit data listed in this subdivision or may require the submission of data not listed in this subdivision provided the omission or submission is necessary for the purpose of complying with the electronic reporting or data transmission standards of the American Society for Automation in Pharmacy, the National Council on Prescription Drug Programs, or other relevant national standard-setting body.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

~~(1) individuals residing in licensed skilled nursing or intermediate care facilities;~~

~~(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;~~

~~(3) individuals receiving medication intravenously;~~

~~(4) individuals receiving hospice and other palliative or end-of-life care; and~~

~~(5) individuals receiving services from a home care provider regulated under chapter 144A.~~

(1) individuals residing in a health care facility as defined in section 151.58, subdivision 2, paragraph (b), when a drug is distributed through the use of an automated drug distribution system according to section 151.58; and

(2) individuals receiving a drug sample that was packaged by a manufacturer and provided to the dispenser for dispensing as a professional sample pursuant to Code of Federal Regulations, title 21, section 203, subpart D.

(d) A dispenser must ~~not submit data under this subdivision unless~~ provide to the patient for whom the prescription was written a conspicuous notice of the reporting requirements of this section ~~is given to the patient for whom the prescription was written~~ and notice that the information may be used for program administration purposes.

Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. Except as otherwise allowed under subdivision 6, the database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or substantiate a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be ~~retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from the last day of the month during which the data was received.~~ made available to permissible users for a 12-month period beginning the day the data was received and ending 12 months from the last day of the month in which the data was received, except that permissible users defined in subdivision 6, paragraph (b), clauses (5) and (6), may use all data collected under this section for the purposes of administering, operating, and maintaining the prescription monitoring program and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program. Data retained beyond 12 months must be de-identified.

(e) The board may retain data reported under subdivision 4 for up to three years from the date the data was received. The board must destroy the data by the end of the three-year period.

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; or

(iii) providing other medical treatment for which access to the data may be necessary 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) 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;

(4) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee;

(5) 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;

(6) authorized personnel of a vendor under contract with the ~~board~~ state of Minnesota who are engaged in the design, implementation, operation, and maintenance of

the ~~electronic reporting system~~ 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 requirements related to the de-identification, retention, and destruction of data specified in subdivision 5, paragraphs (d) and (e);

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

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

(9) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (h); and

(10) 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 ~~(3)~~ (4), access by an individual includes persons in the definition of an individual under section 13.02.

(c) ~~Any~~ A permissible user identified in paragraph (b), ~~who~~ clauses (1), (2), (5), (6), and (8) may directly ~~accesses~~ 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.

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

~~(e) The board shall not release the name of a prescriber without the written consent of the prescriber or a valid search warrant or court order. The board shall provide a~~

~~mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.~~

~~(f)~~ (e) 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)~~ (f) 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)~~ (g) 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, part 2.34, item (c), prior to implementing this paragraph.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.

~~Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting system to determine if the system is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.~~

~~(b) The board shall submit the evaluation of the system to the legislature by July 15, 2011.~~

Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit charitable foundations, the federal government, and other sources to fund the enhancement and ongoing operations of the prescription ~~electronic reporting system~~ monitoring program established under this section. Any funds received shall be appropriated to the board for this purpose. The board may not expend funds to enhance the program in a way that conflicts with this section without seeking approval from the legislature.

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

Sec. 6. **[604A.04] GOOD SAMARITAN OVERDOSE PREVENTION.**

Subdivision 1. **Definitions; opiate antagonist.** For purposes of this section, "opiate antagonist" means naloxone hydrochloride or any similarly acting drug approved by the federal Food and Drug Administration for the treatment of a drug overdose.

Subd. 2. **Authority to possess and administer opiate antagonists; release from liability.** (a) A person who is not a health care professional may possess or administer an opiate antagonist that is prescribed, dispensed, or distributed by a licensed health care professional pursuant to subdivision 3.

(b) A person who is not a health care professional who acts in good faith in administering an opiate antagonist to another person whom the person believes in good faith to be suffering a drug overdose is immune from criminal prosecution for the act and is not liable for any civil damages for acts or omissions resulting from the act.

Subd. 3. **Health care professionals; release from liability.** A licensed health care professional who is permitted by law to prescribe an opiate antagonist, if acting in good faith, may directly or by standing order prescribe, dispense, distribute, or administer an opiate antagonist to a person without being subject to civil liability or criminal prosecution for the act. This immunity applies even when the opiate antagonist is eventually administered in either or both of the following instances: (1) by someone other than the person to whom it is prescribed; or (2) to someone other than the person to whom it is prescribed. This subdivision does not apply if the licensed health care professional is acting during the course of regular employment and receiving compensation or expecting to receive compensation for those actions.

**EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to actions arising from incidents occurring on or after that date.

Sec. 7. **[604A.05] GOOD SAMARITAN OVERDOSE MEDICAL ASSISTANCE.**

Subdivision 1. **Person seeking medical assistance; immunity from prosecution.** A person acting in good faith who seeks medical assistance for another person who is experiencing a drug overdose may not be arrested, charged, prosecuted, or penalized, or have that person's property subject to civil forfeiture for the possession, sharing, or use of a controlled substance or drug paraphernalia; or a violation of a condition of pretrial release, probation, furlough, supervised release, or parole. A person qualifies for the immunities provided in this subdivision only if: (1) the evidence for the arrest, charge, prosecution, seizure, or penalty was obtained as a result of the person's seeking medical assistance for another person; and (2) the person seeks medical assistance for another person who is in need of medical assistance for an immediate health or safety concern, provided that the person who seeks the medical assistance is the first person to seek the assistance, provides the person's name and contact information, remains on the scene until assistance arrives and is provided, and cooperates with the authorities.

Subd. 2. **Person experiencing an overdose; immunity from prosecution.** A person who experiences a drug overdose and is in need of medical assistance may not be arrested, charged, prosecuted, or penalized, or have that person's property subject to civil forfeiture for: (1) the possession of a controlled substance or drug paraphernalia; or (2) a violation of a condition of pretrial release, probation, furlough, supervised release, or parole. A person qualifies for the immunities provided in this subdivision only if the evidence for the arrest, charge, prosecution, seizure, or penalty was obtained as a result of the drug overdose and the need for medical assistance.

Subd. 3. **Effect on other criminal prosecutions.** (a) The immunity provisions of this section do not preclude prosecution of the person on the basis of evidence obtained from an independent source.

(b) The act of providing first aid or other medical assistance to someone who is experiencing a drug overdose may be used as a mitigating factor in a criminal prosecution for which immunity is not provided.

**EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to actions arising from incidents occurring on or after that date.

Sec. 8. **CITATION.**

Sections 6 and 7 may be known and cited as "Steve's Law."

Sec. 9. **STUDY REQUIRED; PRESCRIPTION MONITORING PROGRAM DATABASE.**

The Board of Pharmacy, in collaboration with the Prescription Monitoring Program Advisory Task Force, shall report to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over health and human services policy and finance, by December 15, 2014, with:

(1) recommendations on whether or not to require the use of the prescription monitoring program database by prescribers when prescribing or considering prescribing, and pharmacists when dispensing or considering dispensing, a controlled substance as defined in Minnesota Statutes, section 152.126, subdivision 1, paragraph (c);

(2) an analysis of the impact of the prescription monitoring program on rates of chemical abuse and prescription drug abuse; and

(3) recommendations on approaches to encourage access to appropriate treatment for prescription drug abuse, through the prescription monitoring program.

# ARTICLE 3

# CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 245A.03, subdivision 6a, is amended to read:

Subd. 6a. **Adult foster care homes serving people with mental illness; certification.** (a) The commissioner of human services shall issue a mental health certification for adult foster care homes licensed under this chapter and Minnesota Rules, parts 9555.5105 to 9555.6265, that serve people with a primary diagnosis of mental illness where the home is not the primary residence of the license holder when a provider is determined to have met the requirements under paragraph (b). This certification is voluntary for license holders. The certification shall be printed on the license, and identified on the commissioner's public Web site.

(b) The requirements for certification are:

(1) all staff working in the adult foster care home have received at least seven hours of annual training under paragraph (c) covering all of the following topics:

(i) mental health diagnoses;

(ii) mental health crisis response and de-escalation techniques;

(iii) recovery from mental illness;

(iv) treatment options including evidence-based practices;

(v) medications and their side effects;

(vi) suicide intervention, identifying suicide warning signs, and appropriate responses;

(vii) co-occurring substance abuse and health conditions; and

~~(vii)~~ (viii) community resources;

(2) a mental health professional, as defined in section 245.462, subdivision 18, or a mental health practitioner as defined in section 245.462, subdivision 17, are available for consultation and assistance;

(3) there is a ~~plan and~~ protocol in place to address a mental health crisis; and

(4) there is a crisis plan for each ~~individual's Individual Placement Agreement~~ individual that identifies who is providing clinical services and their contact information, and includes an individual crisis prevention and management plan developed with the individual.

(c) The training curriculum must be approved by the commissioner of human services and must include a testing component after training is completed. Training must be provided by a mental health professional or a mental health practitioner. Training may

also be provided by an individual living with a mental illness or a family member of such an individual, who is from a nonprofit organization with a history of providing educational classes on mental illnesses approved by the Department of Human Services to deliver mental health training. Staff must receive three hours of training in the areas specified in paragraph (b), clause (1), items (i) and (ii), prior to working alone with residents. The remaining hours of mandatory training, including a review of the information in paragraph (b), clause (1), item (ii), must be completed within six months of the hire date. For programs licensed under chapter 245D, training under this chapter may be incorporated into the 30 hours of staff orientation training required under section 245D.09, subdivision 4.

~~(c)~~ (d) License holders seeking certification under this subdivision must request this certification on forms provided by the commissioner and must submit the request to the county licensing agency in which the home is located. The county licensing agency must forward the request to the commissioner with a county recommendation regarding whether the commissioner should issue the certification.

~~(d)~~ (e) Ongoing compliance with the certification requirements under paragraph (b) shall be reviewed by the county licensing agency at each licensing review. When a county licensing agency determines that the requirements of paragraph (b) are not met, the county shall inform the commissioner, and the commissioner will remove the certification.

~~(e)~~ (f) A denial of the certification or the removal of the certification based on a determination that the requirements under paragraph (b) have not been met by the adult foster care license holder are not subject to appeal. A license holder that has been denied a certification or that has had a certification removed may again request certification when the license holder is in compliance with the requirements of paragraph (b).

Sec. 2. Minnesota Statutes 2013 Supplement, section 245D.33, is amended to read:

**245D.33 ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**

(a) The commissioner of human services shall issue a mental health certification for services licensed under this chapter when a license holder is determined to have met the requirements under section 245A.03, subdivision 6a, paragraph (b). This certification is voluntary for license holders. The certification shall be printed on the license and identified on the commissioner's public Web site.

(b) ~~The requirements for certification are:~~

~~(1) all staff have received at least seven hours of annual training covering all of the following topics:~~

~~(i) mental health diagnoses;~~

~~(ii) mental health crisis response and de-escalation techniques;~~

~~(iii) recovery from mental illness;~~

~~(iv) treatment options, including evidence-based practices;~~

~~(v) medications and their side effects;~~

~~(vi) co-occurring substance abuse and health conditions; and~~

~~(vii) community resources;~~

~~(2) a mental health professional, as defined in section 245.462, subdivision 18, or a mental health practitioner as defined in section 245.462, subdivision 17, is available for consultation and assistance;~~

~~(3) there is a plan and protocol in place to address a mental health crisis; and~~

~~(4) each person's individual service and support plan identifies who is providing clinical services and their contact information, and includes an individual crisis prevention and management plan developed with the person.~~

~~(c)~~ License holders seeking certification under this section must request this certification on forms and in the manner prescribed by the commissioner.

~~(d)~~ (c) If the commissioner finds that the license holder has failed to comply with the certification requirements under section 245A.03, subdivision 6a, paragraph (b), the commissioner may issue a correction order and an order of conditional license in accordance with section 245A.06 or may issue a sanction in accordance with section 245A.07, including and up to removal of the certification.

~~(e)~~ (d) A denial of the certification or the removal of the certification based on a determination that the requirements under section 245A.03, subdivision 6a, paragraph (b) have not been met is not subject to appeal. A license holder that has been denied a certification or that has had a certification removed may again request certification when the license holder is in compliance with the requirements of section 245A.03, subdivision 6a, paragraph (b).

Sec. 3. Minnesota Statutes 2012, section 253B.092, subdivision 2, is amended to read:

Subd. 2. **Administration without judicial review.** Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care directive under chapter 145C or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) the patient has been prescribed neuroleptic medication but lacks the capacity to consent to the administration of that neuroleptic medication upon admission to the

treatment facility; continued administration of the medication is in the patient's best interest; and the patient does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating physician:

(i) is obtaining a substitute decision-maker appointed by the court under subdivision 6; or

(ii) is requesting an amendment to a current court order authorizing administration of neuroleptic medication;

(4) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

~~(4)~~ (5) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

Sec. 4. Minnesota Statutes 2013 Supplement, section 254A.035, subdivision 2, is amended to read:

Subd. 2. **Membership terms, compensation, removal and expiration.** The membership of this council shall be composed of 17 persons who are American Indians and who are appointed by the commissioner. The commissioner shall appoint one representative from each of the following groups: Red Lake Band of Chippewa Indians; Fond du Lac Band, Minnesota Chippewa Tribe; Grand Portage Band, Minnesota Chippewa Tribe; Leech Lake Band, Minnesota Chippewa Tribe; Mille Lacs Band, Minnesota Chippewa Tribe; Bois Forte Band, Minnesota Chippewa Tribe; White Earth Band, Minnesota Chippewa Tribe; Lower Sioux Indian Reservation; Prairie Island Sioux Indian Reservation; Shakopee Mdewakanton Sioux Indian Reservation; Upper Sioux Indian Reservation; International Falls Northern Range; Duluth Urban Indian Community; and two representatives from the Minneapolis Urban Indian Community and two from the St. Paul Urban Indian Community. The terms, compensation, and removal of American Indian Advisory Council members shall be as provided in section 15.059. The council expires June 30, ~~2014~~ 2018.

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

Sec. 5. Minnesota Statutes 2013 Supplement, section 254A.04, is amended to read:

**254A.04 CITIZENS ADVISORY COUNCIL.**

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of alcohol and other drug dependency and abuse, composed of ten members. Five members shall be individuals whose interests or training are in the field of alcohol dependency and abuse; and five members whose interests or training are in the field of dependency and abuse of drugs other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June 30, ~~2014~~ 2018. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

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

Sec. 6. Minnesota Statutes 2012, section 254B.01, is amended by adding a subdivision to read:

Subd. 8. **Culturally specific program.** (a) "Culturally specific program" means a substance use disorder treatment service program that is recovery-focused and culturally specific when the program:

(1) improves service quality to and outcomes of a specific population by advancing health equity to help eliminate health disparities; and

(2) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific population's values, beliefs and practices, health literacy, preferred language, and other communication needs.

(b) A tribally licensed substance use disorder program that is designated as serving a culturally specific population by the applicable tribal government is deemed to satisfy this subdivision.

Sec. 7. Minnesota Statutes 2012, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) medication-assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

(3) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (2) and provide nine hours of clinical services each week;

(4) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(5) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(6) adolescent treatment programs that are licensed as outpatient treatment programs according to Minnesota Rules, parts 9530.6405 to 9530.6485, or as residential treatment programs according to Minnesota Rules, chapter 2960, or applicable tribal license; and

(7) room and board facilities that meet the requirements of section 254B.05, subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and the following additional requirements:

(1) programs that serve parents with their children if the program meets the additional licensing requirement in Minnesota Rules, part 9530.6490, and provides child care that meets the requirements of section 245A.03, subdivision 2, during hours of treatment activity;

(2) culturally specific programs ~~serving special populations~~ as defined in section 254B.01, subdivision 8, if the program meets the requirements in Minnesota Rules, part 9530.6605, subpart 13;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in Minnesota Rules, part 9530.6495;

(ii) 25 percent of the counseling staff are mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff will receive eight hours of co-occurring disorder training annually.

(d) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0580 to 2960.0700, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

Sec. 8. Minnesota Statutes 2013 Supplement, section 260.835, subdivision 2, is amended to read:

Subd. 2. **Expiration.** Notwithstanding section 15.059, subdivision 5, the American Indian Child Welfare Advisory Council expires June 30, ~~2014~~ 2018.

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

Sec. 9. Minnesota Statutes 2012, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this chapter, chapter 260D, and section 245.487, subdivision 3. Screenings shall be conducted within 15 days of a request for a screening, unless the screening is for the purpose of placement in mental health residential treatment and the child is enrolled in a prepaid health program under section 256B.69 in which case the screening shall be conducted within ten working days of a request. The team, which may be the team constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655, shall consist of social workers, juvenile justice professionals, persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability, and the child's parent, guardian, or permanent legal custodian under Minnesota Statutes 2010, section 260C.201, subdivision 11, or section 260C.515, subdivision 4. The team may be the same team as defined in section 260B.157, subdivision 3.

(b) The social services agency shall determine whether a child brought to its attention for the purposes described in this section is an Indian child, as defined in section 260C.007, subdivision 21, and shall determine the identity of the Indian child's tribe, as defined in section 260.755, subdivision 9. When a child to be evaluated is an Indian child, the team provided in paragraph (a) shall include a designated representative of the Indian child's tribe, unless the child's tribal authority declines to appoint a representative. The

Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12.

(c) If the court, prior to, or as part of, a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a postdispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall ascertain whether the child is an Indian child and shall notify the county welfare agency and, if the child is an Indian child, shall notify the Indian child's tribe. The county's juvenile treatment screening team must either: (i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or (ii) elect not to screen a given case and notify the court of that decision within three working days.

(d) The child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

(e) When the county's juvenile treatment screening team has elected to screen and evaluate a child determined to be an Indian child, the team shall provide notice to the tribe or tribes that accept jurisdiction for the Indian child or that recognize the child as a member of the tribe or as a person eligible for membership in the tribe, and permit the tribe's representative to participate in the screening team.

(f) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

Sec. 10. **PILOT PROGRAM; NOTICE AND INFORMATION TO COMMISSIONER OF HUMAN SERVICES REGARDING PATIENTS COMMITTED TO COMMISSIONER.**

The commissioner of human services may create a pilot program that is designed to respond to issues that were raised in the February 2013 Office of the Legislative Auditor report on state-operated services. The pilot program may include no more than three counties to test the efficacy of providing notice and information to the commissioner prior to or when a petition is filed to commit a patient exclusively to the commissioner. The commissioner shall provide a status update to the chairs and ranking minority members of the legislative committees with jurisdiction over civil commitment and human services issues, no later than January 15, 2015.

## ARTICLE 4

## HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2012, section 148.01, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of sections 148.01 to 148.10:

(1) "chiropractic" ~~is defined as the science of adjusting any abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain or deranged function; and~~ means the health care discipline that recognizes the innate recuperative power of the body to heal itself without the use of drugs or surgery by identifying and caring for vertebral subluxations and other abnormal articulations by emphasizing the relationship between structure and function as coordinated by the nervous system and how that relationship affects the preservation and restoration of health;

(2) "chiropractic services" means the evaluation and facilitation of structural, biomechanical, and neurological function and integrity through the use of adjustment, manipulation, mobilization, or other procedures accomplished by manual or mechanical forces applied to bones or joints and their related soft tissues for correction of vertebral

subluxation, other abnormal articulations, neurological disturbances, structural alterations, or biomechanical alterations, and includes, but is not limited to, manual therapy and mechanical therapy as defined in section 146.23;

(3) "abnormal articulation" means the condition of opposing bony joint surfaces and their related soft tissues that do not function normally, including subluxation, fixation, adhesion, degeneration, deformity, dislocation, or other pathology that results in pain or disturbances within the nervous system, results in postural alteration, inhibits motion, allows excessive motion, alters direction of motion, or results in loss of axial loading efficiency, or a combination of these;

(4) "diagnosis" means the physical, clinical, and laboratory examination of the patient, and the use of diagnostic services for diagnostic purposes within the scope of the practice of chiropractic described in sections 148.01 to 148.10;

(5) "diagnostic services" means clinical, physical, laboratory, and other diagnostic measures, including diagnostic imaging that may be necessary to determine the presence or absence of a condition, deficiency, deformity, abnormality, or disease as a basis for evaluation of a health concern, diagnosis, differential diagnosis, treatment, further examination, or referral;

(6) "therapeutic services" means rehabilitative therapy as defined in Minnesota Rules, part 2500.0100, subpart 11, and all of the therapeutic, rehabilitative, and preventive sciences and procedures for which the licensee was subject to examination under section 148.06. When provided, therapeutic services must be performed within a practice where the primary focus is the provision of chiropractic services, to prepare the patient for chiropractic services, or to complement the provision of chiropractic services. The administration of therapeutic services is the responsibility of the treating chiropractor and must be rendered under the direct supervision of qualified staff;

(7) "acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment. Acupuncture may not be used as an independent therapy or separately from chiropractic services. Acupuncture is permitted under section 148.01 only after registration with the board which requires completion of a board-approved course of study and successful completion of a board-approved national examination on acupuncture. Renewal of registration shall require completion of board-approved continuing education requirements in acupuncture. The restrictions of section 147B.02, subdivision 2, apply to individuals registered to perform acupuncture under this section; and

~~(2)~~ (8) "animal chiropractic diagnosis and treatment" means treatment that includes identifying and resolving vertebral subluxation complexes, spinal manipulation, and manipulation of the extremity articulations of nonhuman vertebrates. Animal chiropractic diagnosis and treatment does not include:

(i) performing surgery;

(ii) dispensing or administering of medications; or

(iii) performing traditional veterinary care and diagnosis.

Sec. 2. Minnesota Statutes 2012, section 148.01, subdivision 2, is amended to read:

Subd. 2. **Exclusions.** The practice of chiropractic is not the practice of medicine, surgery, ~~or~~ osteopathy, or physical therapy.

Sec. 3. Minnesota Statutes 2012, section 148.01, is amended by adding a subdivision to read:

Subd. 4. **Practice of chiropractic.** An individual licensed to practice under section 148.06 is authorized to perform chiropractic services, acupuncture, therapeutic services, and to provide diagnosis and to render opinions pertaining to those services for the purpose of determining a course of action in the best interests of the patient, such as a treatment plan, appropriate referral, or both.

Sec. 4. Minnesota Statutes 2012, section 148.105, subdivision 1, is amended to read:

Subdivision 1. **Generally.** Any person who practices, or attempts to practice, chiropractic or who uses any of the terms or letters "Doctors of Chiropractic," "Chiropractor," "DC," or any other title or letters under any circumstances as to lead the public to believe that the person who so uses the terms is engaged in the practice of chiropractic, without having complied with the provisions of sections 148.01 to 148.104, is guilty of a gross misdemeanor; and, upon conviction, fined not less than $1,000 nor more than $10,000 or be imprisoned in the county jail for not less than 30 days nor more than six months or punished by both fine and imprisonment, in the discretion of the court. It is the duty of the county attorney of the county in which the person practices to prosecute. Nothing in sections 148.01 to 148.105 shall be considered as interfering with any person:

(1) licensed by a health-related licensing board, as defined in section 214.01, subdivision 2, including psychological practitioners with respect to the use of hypnosis;

(2) registered or licensed by the commissioner of health under section 214.13; or

(3) engaged in other methods of healing regulated by law in the state of Minnesota;

provided that the person confines activities within the scope of the license or other regulation and does not practice or attempt to practice chiropractic.

Sec. 5. Minnesota Statutes 2012, section 148.6402, subdivision 17, is amended to read:

Subd. 17. **Physical agent modalities.** "Physical agent modalities" mean modalities that use the properties of light, water, temperature, sound, or electricity to produce a response in soft tissue. ~~The physical agent modalities referred to in sections 148.6404 and 148.6440 are superficial physical agent modalities, electrical stimulation devices, and ultrasound.~~

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

Sec. 6. Minnesota Statutes 2012, section 148.6404, is amended to read:

**148.6404 SCOPE OF PRACTICE.**

The practice of occupational therapy by an occupational therapist or occupational therapy assistant includes, but is not limited to, intervention directed toward:

(1) assessment and evaluation, including the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements, to identify areas for occupational therapy services;

(2) providing for the development of sensory integrative, neuromuscular, or motor components of performance;

(3) providing for the development of emotional, motivational, cognitive, or psychosocial components of performance;

(4) developing daily living skills;

(5) developing feeding and swallowing skills;

(6) developing play skills and leisure capacities;

(7) enhancing educational performance skills;

(8) enhancing functional performance and work readiness through exercise, range of motion, and use of ergonomic principles;

(9) designing, fabricating, or applying rehabilitative technology, such as selected orthotic and prosthetic devices, and providing training in the functional use of these devices;

(10) designing, fabricating, or adapting assistive technology and providing training in the functional use of assistive devices;

(11) adapting environments using assistive technology such as environmental controls, wheelchair modifications, and positioning;

(12) employing physical agent modalities, in preparation for or as an adjunct to purposeful activity, within the same treatment session or to meet established functional occupational therapy goals~~, consistent with the requirements of section 148.6440~~; and

(13) promoting health and wellness.

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

Sec. 7. Minnesota Statutes 2012, section 148.6430, is amended to read:

**148.6430 DELEGATION OF DUTIES; ASSIGNMENT OF TASKS.**

The occupational therapist is responsible for all duties delegated to the occupational therapy assistant or tasks assigned to direct service personnel. The occupational therapist may delegate to an occupational therapy assistant those portions of a client's evaluation, reevaluation, and treatment that, according to prevailing practice standards of the American Occupational Therapy Association, can be performed by an occupational therapy assistant. The occupational therapist may not delegate portions of an evaluation or reevaluation of a person whose condition is changing rapidly. ~~Delegation of duties related to use of physical agent modalities to occupational therapy assistants is governed by section 148.6440, subdivision 6.~~

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

Sec. 8. Minnesota Statutes 2012, section 148.6432, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** If the professional standards identified in section 148.6430 permit an occupational therapist to delegate an evaluation, reevaluation, or treatment procedure, the occupational therapist must provide supervision consistent with this section. ~~Supervision of occupational therapy assistants using physical agent modalities is governed by section 148.6440, subdivision 6.~~

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

Sec. 9. Minnesota Statutes 2012, section 148.7802, subdivision 3, is amended to read:

Subd. 3. **Approved education program.** "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by ~~the National Athletic Trainers Association Professional Education Committee, the National Athletic Trainers Association Board of Certification, or the Joint Review Committee on Educational Programs in Athletic Training in collaboration with the American Academy~~

~~of Family Physicians, the American Academy of Pediatrics, the American Medical Association, and the National Athletic Trainers Association~~ a nationally recognized accreditation agency for athletic training education programs approved by the board.

Sec. 10. Minnesota Statutes 2012, section 148.7802, subdivision 9, is amended to read:

Subd. 9. **Credentialing examination.** "Credentialing examination" means an examination administered by the ~~National Athletic Trainers Association~~ Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Sec. 11. Minnesota Statutes 2012, section 148.7803, subdivision 1, is amended to read:

Subdivision 1. **Designation.** A person shall not use in connection with the person's name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota registered athletic trainer; athletic trainer; AT; ATR; or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a certificate of registration as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as ~~a "student athletic trainer."~~ an "athletic training student."

Sec. 12. Minnesota Statutes 2012, section 148.7805, subdivision 1, is amended to read:

Subdivision 1. ~~**Creation;**~~ **Membership.** The Athletic Trainers Advisory Council is created and is composed of eight members appointed by the board. The advisory council consists of:

(1) two public members as defined in section 214.02;

(2) three members who~~, except for initial appointees,~~ are registered athletic trainers, one being both a licensed physical therapist and registered athletic trainer as submitted by the Minnesota American Physical Therapy Association;

(3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and

(4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Sec. 13. Minnesota Statutes 2012, section 148.7808, subdivision 1, is amended to read:

Subdivision 1. **Registration.** The board may issue a certificate of registration as an athletic trainer to applicants who meet the requirements under this section. An applicant

for registration as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board, that includes:

(1) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;

(2) evidence satisfactory to the board of the successful completion of an education program approved by the board;

(3) educational background;

(4) proof of a baccalaureate or master's degree from an accredited college or university;

(5) credentials held in other jurisdictions;

(6) a description of any other jurisdiction's refusal to credential the applicant;

(7) a description of all professional disciplinary actions initiated against the applicant in any other jurisdiction;

(8) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(9) evidence satisfactory to the board of a qualifying score on a credentialing examination ~~within one year of the application for registration~~;

(10) additional information as requested by the board;

(11) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and

(12) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Sec. 14. Minnesota Statutes 2012, section 148.7808, subdivision 4, is amended to read:

Subd. 4. **Temporary registration.** (a) The board may issue a temporary registration as an athletic trainer to qualified applicants. A temporary registration is issued for ~~one year~~ 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within ~~one year~~ 120 days after the date of the temporary registration. A temporary registration may not be renewed.

(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).

(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than ~~four~~

two athletic trainers with temporary registrations shall work under the direction of a registered athletic trainer.

Sec. 15. Minnesota Statutes 2012, section 148.7812, subdivision 2, is amended to read:

Subd. 2. **Approved programs.** The board shall approve a continuing education program that has been approved for continuing education credit by the ~~National Athletic Trainers Association~~ Board of Certification, or the board's recognized successor.

Sec. 16. Minnesota Statutes 2012, section 148.7813, is amended by adding a subdivision to read:

Subd. 5. **Discipline; reporting.** For the purposes of this chapter, registered athletic trainers and applicants are subject to sections 147.091 to 147.162.

Sec. 17. Minnesota Statutes 2012, section 148.7814, is amended to read:

**148.7814 APPLICABILITY.**

Sections 148.7801 to 148.7815 do not apply to persons who are certified as athletic trainers by the ~~National Athletic Trainers Association~~ Board of Certification or the board's recognized successor and come into Minnesota for a specific athletic event or series of athletic events with an individual or group.

Sec. 18. Minnesota Statutes 2012, section 148.995, subdivision 2, is amended to read:

Subd. 2. **Certified doula.** "Certified doula" means an individual who has received a certification to perform doula services from the International Childbirth Education Association, the Doulas of North America (DONA), the Association of Labor Assistants and Childbirth Educators (ALACE), the Birthworks, the Childbirth and Postpartum Professional Association (CAPPA), the Childbirth International, ~~or~~ the International Center for Traditional Childbearing, or the Birth Place/Common Childbirth, Inc.

Sec. 19. Minnesota Statutes 2012, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional as defined in section 245.462,

subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6), or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 20. Minnesota Statutes 2012, section 148B.5301, subdivision 4, is amended to read:

Subd. 4. **Conversion to licensed professional clinical counselor after August 1, 2014.** ~~After August 1, 2014, an individual licensed in the state of Minnesota as a licensed professional counselor may convert to a LPCC by providing evidence satisfactory to the board that the applicant has met the requirements of subdivisions 1 and 2, subject to the following:~~

~~(1) the individual's license must be active and in good standing;~~

~~(2) the individual must not have any complaints pending, uncompleted disciplinary orders, or corrective action agreements; and~~

~~(3) the individual has paid the LPCC application and licensure fees required in section 148B.53, subdivision 3.~~ (a) After August 1, 2014, an individual currently licensed in the state of Minnesota as a licensed professional counselor may convert to a LPCC by providing evidence satisfactory to the board that the applicant has met the following requirements:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has a license that is active and in good standing;

(4) has no complaints pending, uncompleted disciplinary order, or corrective action agreements;

(5) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board, and whose degree was from a counseling program recognized by CACREP or from an institution of higher education that is accredited by a regional accrediting organization recognized by CHEA;

(6) has earned 24 graduate-level semester credits or quarter-credit equivalents in clinical coursework which includes content in the following clinical areas:

(i) diagnostic assessment for child or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;

(ii) clinical treatment planning with measurable goals;

(iii) clinical intervention methods informed by research evidence and community standards of practice;

(iv) evaluation methodologies regarding the effectiveness of interventions;

(v) professional ethics applied to clinical practice; and

(vi) cultural diversity;

(7) has demonstrated competence in professional counseling by passing the National Clinical Mental Health Counseling Examination (NCMHCE), administered by the National Board for Certified Counselors, Inc. (NBCC), and ethical, oral, and situational examinations as prescribed by the board;

(8) has demonstrated, to the satisfaction of the board, successful completion of 4,000 hours of supervised, post-master's degree professional practice in the delivery of clinical services in the diagnosis and treatment of child and adult mental illnesses and disorders, which includes 1,800 direct client contact hours. A licensed professional counselor who has completed 2,000 hours of supervised post-master's degree clinical professional practice and who has independent practice status need only document 2,000 additional hours of supervised post-master's degree clinical professional practice, which includes 900 direct client contact hours; and

(9) has paid the LPCC application and licensure fees required in section 148B.53, subdivision 3.

(b) If the coursework in paragraph (a) was not completed as part of the degree program required by paragraph (a), clause (5), the coursework must be taken and passed for credit, and must be earned from a counseling program or institution that meets the requirements in paragraph (a), clause (5).

Sec. 21. Minnesota Statutes 2012, section 150A.01, subdivision 8a, is amended to .read:

Subd. 8a. **Resident dentist.** "Resident dentist" means a person who is licensed to practice dentistry as an enrolled graduate student or student of an advanced education program accredited by the ~~American Dental Association~~ Commission on Dental Accreditation.

Sec. 22. Minnesota Statutes 2012, section 150A.06, subdivision 1, is amended to read:

Subdivision 1. **Dentists.** A person of good moral character who has graduated from a dental program accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, having submitted an application and fee as prescribed by the board, may be examined by the board or by an agency pursuant to section 150A.03, subdivision 1, in a manner to test the applicant's fitness to practice dentistry. A graduate of a dental college in another country must not be disqualified from examination solely because of the applicant's foreign training if the board determines that the training is equivalent to or higher than that provided by a dental college accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~. In the case of examinations conducted pursuant to section 150A.03, subdivision 1, applicants shall take the examination prior to applying to the board for licensure. The examination shall include an examination of the applicant's knowledge of the laws of Minnesota relating to dentistry and the rules of the board. An applicant is ineligible to retake the clinical examination required by the board after failing it twice until further education and training are obtained as specified by the board by rule. A separate, nonrefundable fee may be charged for each time a person applies. An applicant who passes the examination in compliance with subdivision 2b, abides by professional ethical conduct requirements, and meets all other requirements of the board shall be licensed to practice dentistry and granted a general dentist license by the board.

Sec. 23. Minnesota Statutes 2012, section 150A.06, subdivision 1a, is amended to read:

Subd. 1a. **Faculty dentists.** (a) Faculty members of a school of dentistry must be licensed in order to practice dentistry as defined in section 150A.05. The board may issue to members of the faculty of a school of dentistry a license designated as either a "limited faculty license" or a "full faculty license" entitling the holder to practice dentistry within the terms described in paragraph (b) or (c). The dean of a school of dentistry and program directors of a Minnesota dental hygiene or dental assisting school accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~ shall certify to the board those members of the school's faculty who practice dentistry but are not licensed to practice dentistry in Minnesota. A faculty member who practices dentistry as defined in section 150A.05, before beginning duties in a school of dentistry or a dental

hygiene or dental assisting school, shall apply to the board for a limited or full faculty license. Pursuant to Minnesota Rules, chapter 3100, and at the discretion of the board, a limited faculty license must be renewed annually and a full faculty license must be renewed biennially. The faculty applicant shall pay a nonrefundable fee set by the board for issuing and renewing the faculty license. The faculty license is valid during the time the holder remains a member of the faculty of a school of dentistry or a dental hygiene or dental assisting school and subjects the holder to this chapter.

(b) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, a license designated as a limited faculty license entitling the holder to practice dentistry within the school and its affiliated teaching facilities, but only for the purposes of teaching or conducting research. The practice of dentistry at a school facility for purposes other than teaching or research is not allowed unless the dentist was a faculty member on August 1, 1993.

(c) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~ a license designated as a full faculty license entitling the holder to practice dentistry within the school and its affiliated teaching facilities and elsewhere if the holder of the license is employed 50 percent time or more by the school in the practice of teaching or research, and upon successful review by the board of the applicant's qualifications as described in subdivisions 1, 1c, and 4 and board rule. The board, at its discretion, may waive specific licensing prerequisites.

Sec. 24. Minnesota Statutes 2012, section 150A.06, subdivision 1c, is amended to read:

Subd. 1c. **Specialty dentists.** (a) The board may grant ~~a~~ one or more specialty ~~license~~ licenses in the specialty areas of dentistry that are recognized by the ~~American Dental Association~~ Commission on Dental Accreditation.

(b) An applicant for a specialty license shall:

(1) have successfully completed a postdoctoral specialty ~~education~~ program accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, or have announced a limitation of practice before 1967;

(2) have been certified by a specialty ~~examining~~ board approved by the Minnesota Board of Dentistry, or provide evidence of having passed a clinical examination for licensure required for practice in any state or Canadian province, or in the case of oral and maxillofacial surgeons only, have a Minnesota medical license in good standing;

(3) have been in active practice or a postdoctoral specialty education program or United States government service at least 2,000 hours in the 36 months prior to applying for a specialty license;

(4) if requested by the board, be interviewed by a committee of the board, which may include the assistance of specialists in the evaluation process, and satisfactorily respond to questions designed to determine the applicant's knowledge of dental subjects and ability to practice;

(5) if requested by the board, present complete records on a sample of patients treated by the applicant. The sample must be drawn from patients treated by the applicant during the 36 months preceding the date of application. The number of records shall be established by the board. The records shall be reasonably representative of the treatment typically provided by the applicant for each specialty area;

(6) at board discretion, pass a board-approved English proficiency test if English is not the applicant's primary language;

(7) pass all components of the National Board Dental Examinations;

(8) pass the Minnesota Board of Dentistry jurisprudence examination;

(9) abide by professional ethical conduct requirements; and

(10) meet all other requirements prescribed by the Board of Dentistry.

(c) The application must include:

(1) a completed application furnished by the board;

(2) at least two character references from two different dentists for each specialty area, one of whom must be a dentist practicing in the same specialty area, and the other from the director of ~~the~~ each specialty program attended;

(3) a licensed physician's statement attesting to the applicant's physical and mental condition;

(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's visual acuity;

(5) a nonrefundable fee; and

(6) a notarized, unmounted passport-type photograph, three inches by three inches, taken not more than six months before the date of application.

(d) A specialty dentist holding ~~a~~ one or more specialty ~~license~~ licenses is limited to practicing in the dentist's designated specialty area or areas. The scope of practice must be defined by each national specialty board recognized by the ~~American Dental Association~~ Commission on Dental Accreditation.

(e) A specialty dentist holding a general ~~dentist~~ dental license is limited to practicing in the dentist's designated specialty area or areas if the dentist has announced a limitation

of practice. The scope of practice must be defined by each national specialty board recognized by the ~~American Dental Association~~ Commission on Dental Accreditation.

(f) All specialty dentists who have fulfilled the specialty dentist requirements and who intend to limit their practice to a particular specialty area or areas may apply for ~~a~~ one or more specialty ~~license~~ licenses.

Sec. 25. Minnesota Statutes 2012, section 150A.06, subdivision 1d, is amended to read:

Subd. 1d. **Dental therapists.** A person of good moral character who has graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the ~~American Dental Association~~ Commission on Dental Accreditation or another board-approved national accreditation organization may apply for licensure.

The applicant must submit an application and fee as prescribed by the board and a diploma or certificate from a dental therapy education program. Prior to being licensed, the applicant must pass a comprehensive, competency-based clinical examination that is approved by the board and administered independently of an institution providing dental therapy education. The applicant must also pass an examination testing the applicant's knowledge of the Minnesota laws and rules relating to the practice of dentistry. An applicant who has failed the clinical examination twice is ineligible to retake the clinical examination until further education and training are obtained as specified by the board. A separate, nonrefundable fee may be charged for each time a person applies. An applicant who passes the examination in compliance with subdivision 2b, abides by professional ethical conduct requirements, and meets all the other requirements of the board shall be licensed as a dental therapist.

Sec. 26. Minnesota Statutes 2012, section 150A.06, subdivision 2, is amended to read:

Subd. 2. **Dental hygienists.** A person of good moral character, who has graduated from a dental hygiene program accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~ and established in an institution accredited by an agency recognized by the United States Department of Education to offer college-level programs, may apply for licensure. The dental hygiene program must provide a minimum of two academic years of dental hygiene education. The applicant must submit an application and fee as prescribed by the board and a diploma or certificate of dental hygiene. Prior to being licensed, the applicant must pass the National Board of Dental Hygiene examination and a board approved examination designed to determine the applicant's clinical competency. In the case of examinations conducted pursuant to section 150A.03, subdivision 1, applicants

shall take the examination before applying to the board for licensure. The applicant must also pass an examination testing the applicant's knowledge of the laws of Minnesota relating to the practice of dentistry and of the rules of the board. An applicant is ineligible to retake the clinical examination required by the board after failing it twice until further education and training are obtained as specified by board rule. A separate, nonrefundable fee may be charged for each time a person applies. An applicant who passes the examination in compliance with subdivision 2b, abides by professional ethical conduct requirements, and meets all the other requirements of the board shall be licensed as a dental hygienist.

Sec. 27. Minnesota Statutes 2012, section 150A.06, subdivision 2a, is amended to read:

Subd. 2a. **Licensed dental assistant.** A person of good moral character, who has graduated from a dental assisting program accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, may apply for licensure. The applicant must submit an application and fee as prescribed by the board and the diploma or certificate of dental assisting. In the case of examinations conducted pursuant to section 150A.03, subdivision 1, applicants shall take the examination before applying to the board for licensure. The examination shall include an examination of the applicant's knowledge of the laws of Minnesota relating to dentistry and the rules of the board. An applicant is ineligible to retake the licensure examination required by the board after failing it twice until further education and training are obtained as specified by board rule. A separate, nonrefundable fee may be charged for each time a person applies. An applicant who passes the examination in compliance with subdivision 2b, abides by professional ethical conduct requirements, and meets all the other requirements of the board shall be licensed as a dental assistant.

Sec. 28. Minnesota Statutes 2012, section 150A.06, subdivision 2d, is amended to read:

Subd. 2d. **Continuing education and professional development waiver.** (a) The board shall grant a waiver to the continuing education requirements under this chapter for a licensed dentist, licensed dental therapist, licensed dental hygienist, or licensed dental assistant who documents to the satisfaction of the board that the dentist, dental therapist, dental hygienist, or licensed dental assistant has retired from active practice in the state and limits the provision of dental care services to those offered without compensation in a public health, community, or tribal clinic or a nonprofit organization that provides services to the indigent or to recipients of medical assistance, general assistance medical care, or MinnesotaCare programs.

(b) The board may require written documentation from the volunteer and retired dentist, dental therapist, dental hygienist, or licensed dental assistant prior to granting this waiver.

(c) The board shall require the volunteer and retired dentist, dental therapist, dental hygienist, or licensed dental assistant to meet the following requirements:

(1) a licensee seeking a waiver under this subdivision must complete and document at least five hours of approved courses in infection control, medical emergencies, and medical management for the continuing education cycle; and

(2) provide documentation of current CPR certification from completion of the American Heart Association healthcare provider course~~,~~ or the American Red Cross professional rescuer course~~, or an equivalent entity~~.

Sec. 29. Minnesota Statutes 2012, section 150A.06, subdivision 3, is amended to read:

Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists or dental hygienists, except that pertaining to the law of Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board, be waived for an applicant who presents a certificate of having passed all components of the National Board Dental Examinations or evidence of having maintained an adequate scholastic standing as determined by the board, in dental school as to dentists, or dental hygiene school as to dental hygienists.

(b) The board shall waive the clinical examination required for licensure for any dentist applicant who is a graduate of a dental school accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, who has passed all components of the National Board Dental Examinations, and who has satisfactorily completed a Minnesota-based postdoctoral general dentistry residency program (GPR) or an advanced education in general dentistry (AEGD) program after January 1, 2004. The postdoctoral program must be accredited by the Commission on Dental Accreditation ~~of the American Dental Association~~, be of at least one year's duration, and include an outcome assessment evaluation assessing the resident's competence to practice dentistry. The board may require the applicant to submit any information deemed necessary by the board to determine whether the waiver is applicable. ~~The board may waive the clinical examination for an applicant who meets the requirements of this paragraph and has satisfactorily completed an accredited postdoctoral general dentistry residency program located outside of Minnesota.~~

Sec. 30. Minnesota Statutes 2012, section 150A.06, subdivision 8, is amended to read:

Subd. 8. **Licensure by credentials.** (a) Any dental assistant may, upon application and payment of a fee established by the board, apply for licensure based on an evaluation of the applicant's education, experience, and performance record in lieu of completing a board-approved dental assisting program for expanded functions as defined in rule, and may be interviewed by the board to determine if the applicant:

(1) has graduated from an accredited dental assisting program accredited by the Commission ~~of~~ on Dental Accreditation ~~of the American Dental Association~~, or is currently certified by the Dental Assisting National Board;

(2) is not subject to any pending or final disciplinary action in another state or Canadian province, or if not currently certified or registered, previously had a certification or registration in another state or Canadian province in good standing that was not subject to any final or pending disciplinary action at the time of surrender;

(3) is of good moral character and abides by professional ethical conduct requirements;

(4) at board discretion, has passed a board-approved English proficiency test if English is not the applicant's primary language; and

(5) has met all expanded functions curriculum equivalency requirements of a Minnesota board-approved dental assisting program.

(b) The board, at its discretion, may waive specific licensure requirements in paragraph (a).

(c) An applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 2a must be licensed to practice the applicant's profession.

(d) If the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 2a, the application must be denied. If licensure is denied, the board may notify the applicant of any specific remedy that the applicant could take which, when passed, would qualify the applicant for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 2a.

(e) A candidate whose application has been denied may appeal the decision to the board according to subdivision 4a.

Sec. 31. Minnesota Statutes 2012, section 150A.091, subdivision 16, is amended to read:

Subd. 16. **Failure of professional development portfolio audit.** ~~A licensee shall submit a fee as established by the board not to exceed the amount of $250 after failing two consecutive professional development portfolio audits and, thereafter, for each failed~~ (a) If

a licensee fails a professional development portfolio audit under Minnesota Rules, part 3100.5300~~.~~, the board is authorized to take the following actions:

(1) for the first failure, the board may issue a warning to the licensee;

(2) for the second failure within ten years, the board may assess a penalty of not more than $250; and

(3) for any additional failures within the ten-year period, the board may assess a penalty of not more than $1,000.

(b) In addition to the penalty fee, the board may initiate the complaint process to address multiple failed audits.

Sec. 32. Minnesota Statutes 2012, section 150A.10, is amended to read:

**150A.10 ALLIED DENTAL PERSONNEL.**

Subdivision 1. **Dental hygienists.** Any licensed dentist, licensed dental therapist, public institution, or school authority may obtain services from a licensed dental hygienist. The licensed dental hygienist may provide those services defined in section 150A.05, subdivision 1a. The services provided shall not include the establishment of a final diagnosis or treatment plan for a dental patient. All services shall be provided under supervision of a licensed dentist. Any licensed dentist who shall permit any dental service by a dental hygienist other than those authorized by the Board of Dentistry, shall be deemed to be violating the provisions of sections 150A.01 to 150A.12, and any unauthorized dental service by a dental hygienist shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 1a. **Limited authorization for dental hygienists.** (a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years;

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist;

(3) has documented participation in courses in infection control and medical emergencies within each continuing education cycle; and

(4) maintains current CPR certification from completion of the American Heart Association healthcare provider course~~,~~ or the American Red Cross professional rescuer course~~, or an equivalent entity~~.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to:

(1) oral health promotion and disease prevention education;

(2) removal of deposits and stains from the surfaces of the teeth;

(3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(4) polishing and smoothing restorations;

(5) removal of marginal overhangs;

(6) performance of preliminary charting;

(7) taking of radiographs; and

(8) performance of scaling and root planing.

The dental hygienist may administer injections of local anesthetic agents or nitrous oxide inhalation analgesia as specifically delegated in the collaborative agreement with a licensed dentist. The dentist need not first examine the patient or be present. If the patient is considered medically compromised, the collaborative dentist shall review the patient record, including the medical history, prior to the provision of these services. Collaborating dental hygienists may work with unlicensed and licensed dental assistants who may only perform duties for which licensure is not required. The performance of dental hygiene services in a health care facility, program, or nonprofit organization as authorized under this subdivision is limited to patients, students, and residents of the facility, program, or organization.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise authorized by the board. The board shall develop parameters and a process for obtaining authorization to collaborate with more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(3) copies of consent to treatment form provided to the patient by the dental hygienist;

(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and

(5) a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist. This procedure must specify where these records are to be located.

The collaborative agreement must be signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization; must be reviewed annually by the collaborating dentist and dental hygienist; and must be made available to the board upon request.

(d) Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. If the dental hygienist makes any referrals to the patient for further dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.

(e) For the purposes of this subdivision, a "health care facility, program, or nonprofit organization" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

(f) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Subd. 2. **Dental assistants.** Every licensed dentist and dental therapist who uses the services of any unlicensed person for the purpose of assistance in the practice of dentistry or dental therapy shall be responsible for the acts of such unlicensed person while engaged in such assistance. The dentist or dental therapist shall permit the unlicensed assistant to perform only those acts which are authorized to be delegated to unlicensed assistants by the Board of Dentistry. The acts shall be performed under supervision of a licensed dentist or dental therapist. A licensed dental therapist shall not supervise more than four ~~registered~~ licensed or unlicensed dental assistants at any one practice setting. The board may permit differing levels of dental assistance based upon recognized educational

standards, approved by the board, for the training of dental assistants. The board may also define by rule the scope of practice of licensed and unlicensed dental assistants. The board by rule may require continuing education for differing levels of dental assistants, as a condition to their license or authority to perform their authorized duties. Any licensed dentist or dental therapist who permits an unlicensed assistant to perform any dental service other than that authorized by the board shall be deemed to be enabling an unlicensed person to practice dentistry, and commission of such an act by an unlicensed assistant shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 3. **Dental technicians.** Every licensed dentist and dental therapist who uses the services of any unlicensed person, other than under the dentist's or dental therapist's supervision and within the same practice setting, for the purpose of constructing, altering, repairing or duplicating any denture, partial denture, crown, bridge, splint, orthodontic, prosthetic or other dental appliance, shall be required to furnish such unlicensed person with a written work order in such form as shall be prescribed by the rules of the board. The work order shall be made in duplicate form, a duplicate copy to be retained in a permanent file of the dentist or dental therapist at the practice setting for a period of two years, and the original to be retained in a permanent file for a period of two years by the unlicensed person in that person's place of business. The permanent file of work orders to be kept by the dentist, dental therapist, or unlicensed person shall be open to inspection at any reasonable time by the board or its duly constituted agent.

Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a licensed dental hygienist or licensed dental assistant may perform the following restorative procedures:

(1) place, contour, and adjust amalgam restorations;

(2) place, contour, and adjust glass ionomer;

(3) adapt and cement stainless steel crowns; ~~and~~

(4) place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel~~.~~; and

(5) place, contour, and adjust class II and class V supragingival composite restorations on primary teeth.

(b) The restorative procedures described in paragraph (a) may be performed only if:

(1) the licensed dental hygienist or licensed dental assistant has completed a board-approved course on the specific procedures;

(2) the board-approved course includes a component that sufficiently prepares the licensed dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed restoration;

(3) a licensed dentist or licensed advanced dental therapist has authorized the procedure to be performed; and

(4) a licensed dentist or licensed advanced dental therapist is available in the clinic while the procedure is being performed.

(c) The dental faculty who teaches the educators of the board-approved courses specified in paragraph (b) must have prior experience teaching these procedures in an accredited dental education program.

Sec. 33. Minnesota Statutes 2012, section 153.16, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** The board shall issue a license to practice podiatric medicine to a person who meets the following requirements:

(a) The applicant for a license shall file a written notarized application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a podiatric medical school approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant factors.

(c) The applicant must have received a passing score on each part of the national board examinations, parts one and two, prepared and graded by the National Board of Podiatric Medical Examiners. The passing score for each part of the national board examinations, parts one and two, is as defined by the National Board of Podiatric Medical Examiners.

(d) Applicants graduating after 1986 from a podiatric medical school shall present evidence ~~satisfactory to the board of the completion of (1) one year of graduate, clinical residency or preceptorship in a program accredited by a national accrediting organization approved by the board or (2) other graduate training that meets standards equivalent to those of an approved national accrediting organization or school of podiatric medicine~~ of successful completion of a residency program approved by a national accrediting podiatric medicine organization.

(e) The applicant shall appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section, including knowledge of laws, rules, and ethics pertaining to the practice of podiatric medicine. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a fee established by the board by rule. The fee shall not be refunded.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee. If the applicant does not satisfy the requirements of this paragraph, the board may refuse to issue a license unless it determines that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(h) Upon payment of a fee as the board may require, an applicant who fails to pass an examination and is refused a license is entitled to reexamination within one year of the board's refusal to issue the license. No more than two reexaminations are allowed without a new application for a license.

Sec. 34. Minnesota Statutes 2012, section 153.16, is amended by adding a subdivision to read:

Subd. 1a. **Relicensure after two-year lapse of practice; reentry program.** A podiatrist seeking licensure or reinstatement of a license after a lapse of continuous practice of podiatric medicine of greater than two years must reestablish competency by completing a reentry program approved by the board.

Sec. 35. Minnesota Statutes 2012, section 153.16, subdivision 2, is amended to read:

Subd. 2. **Applicants licensed in another state.** The board shall issue a license to practice podiatric medicine to any person currently or formerly licensed to practice podiatric medicine in another state who satisfies the requirements of this section:

(a) The applicant shall satisfy the requirements established in subdivision 1.

(b) The applicant shall present evidence satisfactory to the board indicating the current status of a license to practice podiatric medicine issued by the first state of licensure and all other states and countries in which the individual has held a license.

(c) If the applicant has had a license revoked, engaged in conduct warranting disciplinary action against the applicant's license, or been subjected to disciplinary action, in another state, the board may refuse to issue a license unless it determines that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

(d) The applicant shall submit with the license application the following additional information for the five-year period preceding the date of filing of the application: (1) the name and address of the applicant's professional liability insurer in the other state; and (2) the number, date, and disposition of any podiatric medical malpractice settlement or award made to the plaintiff relating to the quality of podiatric medical treatment.

(e) If the license is active, the applicant shall submit with the license application evidence of compliance with the continuing education requirements in the current state of licensure.

(f) If the license is inactive, the applicant shall submit with the license application evidence of participation in ~~one-half~~ the same number of hours of acceptable continuing education required for biennial renewal, as specified under Minnesota Rules, up to five years. If the license has been inactive for more than two years, the amount of acceptable continuing education required must be obtained during the two years immediately before application or the applicant must provide other evidence as the board may reasonably require.

Sec. 36. Minnesota Statutes 2012, section 153.16, subdivision 3, is amended to read:

Subd. 3. **Temporary permit.** Upon payment of a fee and in accordance with the rules of the board, the board may issue a temporary permit to practice podiatric medicine to a podiatrist engaged in a clinical residency ~~or preceptorship for a period not to exceed 12 months. A temporary permit may be extended under the following conditions:~~

~~(1) the applicant submits acceptable evidence that the training was interrupted by circumstances beyond the control of the applicant and that the sponsor of the program agrees to the extension;~~

~~(2) the applicant is continuing in a residency that extends for more than one year; or~~

~~(3) the applicant is continuing in a residency that extends for more than two years.~~ approved by a national accrediting organization. The temporary permit is renewed annually until the residency training requirements are completed or until the residency program is terminated or discontinued.

Sec. 37. Minnesota Statutes 2012, section 153.16, is amended by adding a subdivision to read:

Subd. 4. **Continuing education.** (a) Every podiatrist licensed to practice in this state shall obtain 40 clock hours of continuing education in each two-year cycle of license renewal. All continuing education hours must be earned by verified attendance at or participation in a program or course sponsored by the Council on Podiatric Medical Education or approved by the board. In each two-year cycle, a maximum of eight hours of continuing education credits may be obtained through participation in online courses.

(b) The number of continuing education hours required during the initial licensure period is that fraction of 40 hours, to the nearest whole hour, that is represented by the ratio of the number of days the license is held in the initial licensure period to 730 days.

Sec. 38. **[214.076] CONVICTION OF FELONY-LEVEL CRIMINAL SEXUAL CONDUCT OFFENSE.**

Subdivision 1. **Applicability.** This section applies to the health-related licensing boards as defined in section 214.01, subdivision 2, except the Board of Medical Practice and the Board of Chiropractic Examiners, and also applies to the Board of Barber Examiners, the Board of Cosmetologist Examiners, and professions credentialed by the Minnesota Department of Health, including:

(1) speech-language pathologists and audiologists;

(2) hearing instrument dispensers; and

(3) occupational therapists and occupational therapy assistants.

Subd. 2. **Issuing and renewing credential to practice.** (a) Except as provided in paragraph (e), a credentialing authority listed in subdivision 1 shall not issue or renew a credential to practice to any person who has been convicted on or after August 1, 2014, of any of the provisions of section 609.342, subdivision 1; 609.343, subdivision 1; 609.344, subdivision 1, clauses (c) to (o); or 609.345, subdivision 1, clauses (b) to (o).

(b) A credentialing authority listed in subdivision 1 shall not issue or renew a credential to practice to any person who has been convicted in any other state or country on or after August 1, 2014, of an offense where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a).

(c) A credential to practice is automatically revoked if the credentialed person is convicted of an offense listed in paragraph (a).

(d) For purposes of this section, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

(e) A credentialing authority listed in subdivision 1 may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become credentialed provided that the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for credentialing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant was released from any incarceration or supervisory jurisdiction related to the offense.

A credentialing authority listed in subdivision 1 shall not consider an application under this paragraph if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

**EFFECTIVE DATE.** This section is effective for credentials issued or renewed on or after August 1, 2014.

Sec. 39. **[214.077] TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF HARM.**

(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe continued practice by the regulated person presents an imminent risk of harm, the licensing board shall temporarily suspend the regulated person's professional license. The suspension shall take effect upon written notice to the regulated person and shall specify the reason for the suspension.

(b) The suspension shall remain in effect until the appropriate licensing board or the commissioner completes an investigation and issues a final order in the matter after a hearing.

(c) At the time it issues the suspension notice, the appropriate licensing board shall schedule a disciplinary hearing to be held before the licensing board or pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to being no later than 30 days after issuance of the suspension order.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 40. Minnesota Statutes 2012, section 214.103, subdivision 2, is amended to read:

Subd. 2. **Receipt of complaint.** The boards shall receive and resolve complaints or other communications, whether oral or written, against regulated persons. Before resolving an oral complaint, the executive director or a board member designated by the board to review complaints shall require the complainant to state the complaint in writing or authorize transcribing the complaint. The executive director or the designated board member shall determine whether the complaint alleges or implies a violation of a statute or rule which the board is empowered to enforce. The executive director or the designated board member may consult with the designee of the attorney general as to a board's jurisdiction over a complaint. If the executive director or the designated board member determines that it is necessary, the executive director may seek additional information to determine whether the complaint is jurisdictional or to clarify the nature of the allegations by obtaining records or other written material, obtaining a handwriting sample from the regulated person, clarifying the alleged facts with the complainant, and requesting a written

response from the subject of the complaint. The executive director may authorize a field investigation to clarify the nature of the allegations and the facts that led to the complaint.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 41. Minnesota Statutes 2012, section 214.103, subdivision 3, is amended to read:

Subd. 3. **Referral to other agencies.** The executive director shall forward to another governmental agency any complaints received by the board which do not relate to the board's jurisdiction but which relate to matters within the jurisdiction of another governmental agency. The agency shall advise the executive director of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule which a board is empowered to enforce must be forwarded to the executive director of the board to be processed in accordance with this section. Governmental agencies ~~may~~ shall coordinate and conduct joint investigations of complaints that involve more than one governmental agency.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 42. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision to read:

Subd. 5. **Health professional services program.** The health-related licensing boards shall include information regarding the health professional services program on their Web sites.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 43. Minnesota Statutes 2012, section 214.29, is amended to read:

**214.29 PROGRAM REQUIRED.**

Each health-related licensing board, including the Emergency Medical Services Regulatory Board under chapter 144E, shall ~~either conduct a~~ contract with the health professionals service program under sections 214.31 to 214.37 ~~or contract for a diversion program under section 214.28~~ for a diversion program for regulated professionals who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 44. Minnesota Statutes 2012, section 214.31, is amended to read:

**214.31 AUTHORITY.**

~~Two or more of the health-related licensing boards listed in section 214.01, subdivision 2, may jointly~~ The health professionals services program shall contract with the health-related licensing boards to conduct a health professionals services program to protect the public from persons regulated by the boards who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition. The program does not affect a board's authority to discipline violations of a board's practice act. For purposes of sections 214.31 to 214.37, the emergency medical services regulatory board shall be included in the definition of a health-related licensing board under chapter 144E.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 45. Minnesota Statutes 2012, section 214.32, is amended to read:

**214.32 PROGRAM OPERATIONS AND RESPONSIBILITIES.**

Subdivision 1. **Management.** (a) A Health Professionals Services Program Committee is established, consisting of ~~one person appointed by each participating board, with each participating board having one vote.~~ no fewer than three, or more than six, executive directors of health-related licensing boards or their designees, and two members of the advisory committee established in paragraph (d). Program committee members from the health-related licensing boards shall be appointed by a majority of the executive directors of the health-related licensing boards in July of odd-numbered years. Members from the advisory committee shall be appointed by a majority of advisory committee members in July of odd-numbered years. The program committee shall designate one board to provide administrative management of the program, set the program budget and the pro rata share of program expenses to be borne by each participating board, provide guidance on the general operation of the program, including hiring of program personnel, and ensure that the program's direction is in accord with its authority. The program committee shall establish uniform criteria and procedures governing termination and discharge for all health professionals served by the health professionals services program. If the participating boards change which board is designated to provide administrative management of the program, any appropriation remaining for the program shall transfer to the newly designated board on the effective date of the change. The participating boards must inform the appropriate legislative committees and the commissioner of management

and budget of any change in the administrative management of the program, and the amount of any appropriation transferred under this provision.

(b) The designated board, upon recommendation of the Health Professional Services Program Committee, shall hire the program manager and employees and pay expenses of the program from funds appropriated for that purpose. The designated board may apply for grants to pay program expenses and may enter into contracts on behalf of the program to carry out the purposes of the program. The participating boards shall enter into written agreements with the designated board.

(c) An advisory committee is established ~~to advise the program committee~~ consisting of:

(1) one member appointed by each ~~of the following: the Minnesota Academy of Physician Assistants, the Minnesota Dental Association, the Minnesota Chiropractic Association, the Minnesota Licensed Practical Nurse Association, the Minnesota Medical Association, the Minnesota Nurses Association, and the Minnesota Podiatric Medicine Association~~ of the professional associations whose members are eligible for health professionals services program services; and

(2) ~~one member appointed by each of the professional associations of the other professions regulated by a participating board not specified in clause (1); and~~

~~(3)~~ two public members, as defined by section 214.02.

(d) Members of the advisory committee shall be appointed for two years and members may be reappointed.

(e) The advisory committee shall:

(1) provide advice and consultation to the health professionals services program staff;

(2) serve as a liaison to all regulated health professionals who are eligible to participate in the health professionals services program; and

(3) provide advice and recommendations to the program committee.

Subd. 2. **Services.** (a) The program shall provide the following services to program participants:

(1) referral of eligible regulated persons to qualified professionals for evaluation, treatment, and a written plan for continuing care consistent with the regulated person's illness. The referral shall take into consideration the regulated person's financial resources as well as specific needs;

(2) development of individualized program participation agreements between participants and the program to meet the needs of participants and protect the public. An agreement may include, but need not be limited to, recommendations from the continuing care plan, practice monitoring, health monitoring, practice restrictions, random drug

screening, support group participation, filing of reports necessary to document compliance, and terms for successful completion of the regulated person's program; and

(3) monitoring of compliance by participants with individualized program participation agreements or board orders.

(b) The program may develop services related to sections 214.31 to 214.37 for employers and colleagues of regulated persons from participating boards.

Subd. 3. **Participant costs.** Each program participant shall be responsible for paying for the costs of physical, psychosocial, or other related evaluation, treatment, laboratory monitoring, and random drug screens.

Subd. 4. **Eligibility.** Admission to the health professional services program is available to a person regulated by a participating board who is unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition. Admission in the health professional services program shall be denied to persons:

(1) who have diverted controlled substances for other than self-administration;

(2) who have been terminated from this or any other state professional services program for noncompliance in the program, unless referred by a participating board or the commissioner of health;

(3) currently under a board disciplinary order or corrective action agreement, unless referred by a board;

(4) ~~regulated under sections 214.17 to 214.25, unless referred by a board or by the commissioner of health;~~

~~(5)~~ accused of sexual misconduct; or

~~(6)~~ (5) whose continued practice would create a serious risk of harm to the public.

Subd. 5. **Completion; voluntary termination; discharge.** (a) A regulated person completes the program when the terms of the program participation agreement are fulfilled.

(b) A regulated person may voluntarily terminate participation in the health professionals service program at any time ~~by reporting to the person's board~~ which shall result in the program manager making a report to the regulated person's board under section 214.33, subdivision 3.

(c) The program manager may choose to discharge a regulated person from the program and make a referral to the person's board at any time for reasons including but not limited to: the degree of cooperation and compliance by the regulated person, the inability to secure information or the medical records of the regulated person, or indication of other possible violations of the regulated person's practice act. The regulated person shall be notified in writing by the program manager of any change in the person's program status.

A regulated person who has been terminated or discharged from the program may be referred back to the program for monitoring.

Subd. 6. **Duties of a health related licensing board.** (a) Upon receiving notice from the program manager that a regulated person has been discharged due to noncompliance or voluntary withdrawal, when the appropriate licensing board has probable cause to believe continued practice by the regulated person presents an imminent risk of harm, the licensing board shall temporarily suspend the regulated person's professional license. The suspension shall take effect upon written notice to the regulated person and shall specify the reason for the suspension.

(b) The suspension shall remain in effect until the appropriate licensing board completes an investigation and issues a final order in the matter after a hearing.

(c) At the time it issues the suspension notice, the appropriate licensing board shall schedule a disciplinary hearing to be held before the licensing board or pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to be no later than 30 days after issuance of the suspension order.

(d) This subdivision does not apply to the Office of Complementary and Alternative Health Care Programs.

Sec. 46. Minnesota Statutes 2012, section 214.33, subdivision 3, is amended to read:

Subd. 3. **Program manager.** (a) The program manager shall report to the appropriate participating board a regulated person who:

(1) does not meet program admission criteria~~.~~;

(2) violates the terms of the program participation agreement~~, or~~;

(3) leaves the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement~~.~~;

(4) is subject to the provisions of sections 214.17 to 214.25;

(5) caused identifiable patient harm;

(6) substituted or adulterated medications;

(7) wrote a prescription or caused a prescription to be filled by a pharmacy in the name of a person or veterinary patient for personal use; or

~~The program manager shall report to the appropriate participating board a regulated person who~~ (8) is alleged to have committed violations of the person's practice act that are outside the authority of the health professionals services program as described in sections 214.31 to 214.37.

(b) The program manager shall inform any reporting person of the disposition of the person's report to the program.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 47. Minnesota Statutes 2012, section 214.33, is amended by adding a subdivision to read:

Subd. 5. **Employer mandatory reporting.** (a) An employer of a person licensed or regulated by a health-related licensing board listed in section 214.01, subdivision 2, and health care institutions, and other organizations where the licensed or regulated health care professional is engaged in providing services, shall report to the appropriate licensing board that the licensee or regulated person has diverted narcotics or other controlled substances in violation of state or federal narcotics or controlled substance law when:

(1) the employer or entity making the report has knowledge of the diversion; and

(2) the licensee or regulated person has diverted narcotics from the reporting employer or organization or at the reporting institution.

(b) Subdivision 1 does not waive the requirement to report under this subdivision.

(c) The requirement to report under this subdivision does not apply:

(1) to licensees or regulated persons who are self-employed;

(2) if the knowledge was obtained in the course of a professional-patient relationship and the patient is licensed or regulated by a health licensing board; or

(3) if knowledge of the diversion first becomes known to the employer, health care institution, or other organization, either from:

(i) the licensee or regulated person who has self-reported to the health professional services program and who has returned to work pursuant to the health professional services program participation agreement and monitoring plan; or

(ii) an individual who is serving as a work site monitor approved by the health professional services program for a person described in item (i).

Sec. 48. **[214.355] GROUNDS FOR DISCIPLINARY ACTION.**

Each health-related licensing board, including the Emergency Medical Services Regulatory Board under chapter 144E, shall consider it grounds for disciplinary action if a regulated person violates the terms of the health professionals services program participation agreement or leaves the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 49. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall remove cross-references to the sections repealed in this article wherever they appear in Minnesota Statutes and Minnesota Rules and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

(b) The revisor of statutes shall change the term "physician's assistant" to "physician assistant" wherever that term is found in Minnesota Statutes and Minnesota Rules.

**EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2014.

Sec. 50. **REPEALER.**

(a) (Chiropractors) Minnesota Statutes 2012, section 148.01, subdivision 3, and Minnesota Rules, parts 2500.0100, subparts 3, 4b, and 9b; and 2500.4000, are repealed.

(b) (Health-related licensing boards) Minnesota Statutes 2012, sections 214.28; 214.36; and 214.37, are repealed effective July 1, 2014.

(c) (Occupational therapists) Minnesota Statutes 2013 Supplement, section 148.6440, is repealed the day following final enactment.

(d) (Athletic trainers) Minnesota Statutes 2012, sections 148.7808, subdivision 2; and 148.7813, are repealed.

## ARTICLE 5

## BOARD OF PHARMACY

Section 1. Minnesota Statutes 2012, section 151.01, is amended to read:

**151.01 DEFINITIONS.**

Subdivision 1. **Words, terms, and phrases.** Unless the language or context clearly indicates that a different meaning is intended, the following words, terms, and phrases, for the purposes of this chapter, shall be given the meanings subjoined to them.

Subd. 2. **Pharmacy.** "Pharmacy" means ~~an established~~ a place of business in which ~~prescriptions,~~ prescription drugs~~, medicines, chemicals, and poisons~~ are prepared, compounded, or dispensed~~, vended, or sold to or for the use of patients~~ by or under the supervision of a pharmacist and from which related clinical pharmacy services are delivered.

Subd. 2a. **Limited service pharmacy.** "Limited service pharmacy" means a pharmacy that has been issued a restricted license by the board to perform a limited range of the activities that constitute the practice of pharmacy.

Subd. 3. **Pharmacist.** The term "pharmacist" means an individual with a currently valid license issued by the Board of Pharmacy to practice pharmacy.

Subd. 5. **Drug.** The term "drug" means all medicinal substances and preparations recognized by the United States Pharmacopoeia and National Formulary, or any revision thereof, vaccines and biologicals, and all substances and preparations intended for external and internal use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals, and all substances and preparations, other than food, intended to affect the structure or any function of the bodies of humans or other animals. The term drug shall also mean any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted for human consumption under Minnesota law that, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance listed in section 152.02, subdivisions 2 and 3, or Minnesota Rules, parts 6800.4210 and 6800.4220, regardless of whether the substance is marketed for the purpose of human consumption.

Subd. 6. **Medicine.** The term "medicine" means any remedial agent that has the property of curing, preventing, treating, or mitigating diseases, or that is used for that purpose.

Subd. 7. **Poisons.** The term "poisons" means any substance ~~which~~ that, when introduced into the system, directly or by absorption, produces violent, morbid, or fatal changes, or ~~which~~ that destroys living tissue with which it comes in contact.

Subd. 8. **Chemical.** The term "chemical" means all medicinal or industrial substances, whether simple or compound, or obtained through the process of the science and art of chemistry, whether of organic or inorganic origin.

Subd. 9. **Board or ~~State~~ Board of Pharmacy.** The term "board" or "~~State~~ Board of Pharmacy" means the Minnesota ~~State~~ Board of Pharmacy.

Subd. 10. **Director.** The term "director" means the executive director of the Minnesota ~~State~~ Board of Pharmacy.

Subd. 11. **Person.** The term "person" means an individual, firm, partnership, company, corporation, trustee, association, agency, or other public or private entity.

Subd. 12. **Wholesale.** The term "wholesale" means and includes any sale for the purpose of resale.

Subd. 13. **Commercial purposes.** The phrase "commercial purposes" means the ordinary purposes of trade, agriculture, industry, and commerce, exclusive of the practices of medicine ~~and~~, pharmacy, and other health care professions.

Subd. 14. **Manufacturing.** The term "manufacturing" ~~except in the case of bulk compounding, prepackaging or extemporaneous compounding within a pharmacy,~~ means

~~and includes~~ the production, ~~quality control and standardization by mechanical, physical, chemical, or pharmaceutical means, packing, repacking, tableting, encapsulating, labeling, relabeling, filling or by any other process, of all drugs, medicines, chemicals, or poisons, without exception, for medicinal purposes.~~ preparation, propagation, conversion, or processing of a drug, either directly or indirectly, by extraction from substances of natural origin or independently by means of chemical or biological synthesis. Manufacturing includes the packaging or repackaging of a drug, or the labeling or relabeling of the container of a drug, for resale by pharmacies, practitioners, or other persons. Manufacturing does not include the prepackaging, extemporaneous compounding, or anticipatory compounding of a drug within a licensed pharmacy or by a practitioner, nor the labeling of a container within a pharmacy or by a practitioner for the purpose of dispensing a drug to a patient pursuant to a valid prescription.

Subd. 14a. **Manufacturer.** The term "manufacturer" means any person engaged in manufacturing.

Subd. 14b. **Outsourcing facility.** "Outsourcing facility" means a facility that is registered by the United States Food and Drug Administration pursuant to United States Code, title 21, section 353b.

Subd. 15. **Pharmacist intern.** The term "pharmacist intern" means (1) a natural person satisfactorily progressing toward the degree in pharmacy required for licensure, or (2) a graduate of the University of Minnesota College of Pharmacy, or other pharmacy college approved by the board, who is registered by the ~~State~~ Board of Pharmacy for the purpose of obtaining practical experience as a requirement for licensure as a pharmacist, or (3) a qualified applicant awaiting examination for licensure.

Subd. 15a. **Pharmacy technician.** The term "pharmacy technician" means a person not licensed as a pharmacist or a pharmacist intern, who assists the pharmacist in the preparation and dispensing of medications by performing computer entry of prescription data and other manipulative tasks. A pharmacy technician shall not perform tasks specifically reserved to a licensed pharmacist or requiring professional judgment.

Subd. 16. **Prescription drug order.** The term "prescription drug order" means a ~~signed~~ lawful written ~~order, or an~~, oral, or electronic order ~~reduced to writing, given by~~ of a practitioner ~~licensed to prescribe drugs for patients in the course of the practitioner's practice, issued for an individual patient and containing the following: the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, and the name and address of the prescriber.~~ for a drug for a specific patient. Prescription drug orders for controlled substances must be prepared in accordance with the

provisions of section 152.11 and the federal Controlled Substances Act and the regulations promulgated thereunder.

Subd. 16a. **Prescription.** The term "prescription" means a prescription drug order that is written or printed on paper, an oral order reduced to writing by a pharmacist, or an electronic order. To be valid, a prescription must be issued for an individual patient by a practitioner within the scope and usual course of the practitioner's practice, and must contain the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, the name and address of the practitioner, and a telephone number at which the practitioner can be reached. A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature.

Subd. 16b. **Chart order.** The term "chart order" means a prescription drug order for a drug that is to be dispensed by a pharmacist, or by a pharmacist intern under the direct supervision of a pharmacist, and administered by an authorized person only during the patient's stay in a hospital or long-term care facility. The chart order shall contain the name of the patient, another patient identifier such as birth date or medical record number, the drug ordered, and any directions that the practitioner may prescribe concerning strength, dosage, frequency, and route of administration. The manual or electronic signature of the practitioner must be affixed to the chart order at the time it is written or at a later date in the case of verbal chart orders.

Subd. 17. **Legend drug.** "Legend drug" means a drug ~~which~~ that is required by federal law to ~~bear the following statement, "Caution: Federal law prohibits dispensing without prescription."~~ be dispensed only pursuant to the prescription of a licensed practitioner.

Subd. 18. **Label.** "Label" means a display of written, printed, or graphic matter upon the immediate container of any drug or medicine~~; and a requirement made by or under authority of Laws 1969, chapter 933 that~~. Any word, statement, or other information ~~appearing~~ required by or under the authority of this chapter to appear on the label shall ~~not be considered to be complied with unless such word, statement, or other information~~ also ~~appears~~ appear on the outside container or wrapper, if any there be, of the retail package of such drug or medicine, or ~~is~~ be easily legible through the outside container or wrapper.

Subd. 19. **Package.** "Package" means any container or wrapping in which any drug or medicine is enclosed for use in the delivery or display of that article to retail purchasers, but does not include:

(a) shipping containers or wrappings used solely for the transportation of any such article in bulk or in quantity to manufacturers, packers, processors, or wholesale or retail distributors;

(b) shipping containers or outer wrappings used by retailers to ship or deliver any such article to retail customers if such containers and wrappings bear no printed matter pertaining to any particular drug or medicine.

Subd. 20. **Labeling.** "Labeling" means all labels and other written, printed, or graphic matter (a) upon a drug or medicine or any of its containers or wrappers, or (b) accompanying such article.

Subd. 21. **Federal act.** "Federal act" means the Federal Food, Drug, and Cosmetic Act, United States Code, title 21, section 301, et seq., as amended.

Subd. 22. **Pharmacist in charge.** "Pharmacist in charge" means a duly licensed pharmacist in the state of Minnesota who has been designated in accordance with the rules of the ~~State~~ Board of Pharmacy to assume professional responsibility for the operation of the pharmacy in compliance with the requirements and duties as established by the board in its rules.

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathy duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, or licensed veterinarian. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A, or an advanced practice nurse authorized to prescribe, dispense, and administer under section 148.235. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.

Subd. 24. **Brand name.** "Brand name" means the registered trademark name given to a drug product by its manufacturer, labeler or distributor.

Subd. 25. **Generic name.** "Generic name" means the established name or official name of a drug or drug product.

Subd. 26. **Finished dosage form.** "Finished dosage form" means that form of a drug ~~which~~ that is or is intended to be dispensed or administered to the patient and requires no further manufacturing or processing other than packaging, reconstitution, or labeling.

Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

(1) interpretation and evaluation of prescription drug orders;

(2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);

(3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs;

(4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;

(5) participation in administration of influenza vaccines to all eligible individuals ten years of age and older and all other vaccines to patients 18 years of age and older ~~under standing orders from a physician licensed under chapter 147 or~~ by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced nurse practitioner;

(F) a telephone number at which the physician, physician assistant, or advanced nurse practitioner can be contacted; and

(G) the date and time period for which the protocol is valid;

~~(i)~~ (ii) the pharmacist ~~is trained in~~ has successfully completed a program approved by the ~~American~~ Accreditation Council ~~of Pharmaceutical~~ for Pharmacy Education specifically for the administration of immunizations or ~~graduated from a college of pharmacy in 2001 or thereafter~~ a program approved by the board; ~~and~~

~~(ii)~~ (iii) the pharmacist reports the administration of the immunization to the patient's primary physician or clinic or to the Minnesota Immunization Information Connection; and

(iv) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe

drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(6) participation in the ~~practice of managing drug therapy and modifying~~ initiation, management, modification, and discontinuation of drug therapy~~, according to section 151.21, subdivision 1,~~ according to a written protocol or collaborative practice agreement between ~~the specific pharmacist~~: (i) one or more pharmacists and ~~the individual dentist, optometrist, physician, podiatrist, or veterinarian who is responsible for the patient's care and authorized to independently prescribe drugs~~ one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any ~~significant~~ changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be ~~reported~~ documented by the pharmacist ~~to~~ in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(7) participation in the storage of drugs and the maintenance of records;

(8) ~~responsibility for participation in~~ patient counseling on therapeutic values, content, hazards, and uses of drugs and devices; and

(9) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy.

Subd. 27a. **Protocol.** "Protocol" means:

(1) a specific written plan that describes the nature and scope of activities that a pharmacist may engage in when initiating, managing, modifying, or discontinuing drug therapy as allowed in subdivision 27, clause (6); or

(2) a specific written plan that authorizes a pharmacist to administer vaccines and that complies with subdivision 27, clause (5).

Subd. 27b. **Collaborative practice.** "Collaborative practice" means patient care activities, consistent with subdivision 27, engaged in by one or more pharmacists who have agreed to work in collaboration with one or more practitioners to initiate, manage, and modify drug therapy under specified conditions mutually agreed to by the pharmacists and practitioners.

Subd. 27c. **Collaborative practice agreement.** "Collaborative practice agreement" means a written and signed agreement between one or more pharmacists and one or more practitioners that allows the pharmacist or pharmacists to engage in collaborative practice.

Subd. 28. **Veterinary legend drug.** "Veterinary legend drug" means a drug that is required by federal law to ~~bear the following statement: "Caution: Federal law restricts~~

~~this drug to use by or on the order of a licensed veterinarian."~~ be dispensed only pursuant to the prescription of a licensed veterinarian.

Subd. 29. **Legend medical gas.** "Legend medical gas" means a liquid or gaseous substance used for medical purposes and that is required by federal law to ~~bear the following statement: "Caution: Federal law prohibits dispensing without a prescription."~~ be dispensed only pursuant to the prescription of a licensed practitioner.

Subd. 30. **Dispense or dispensing.** "Dispense or dispensing" means the ~~preparation or delivery of a drug pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the drug.~~ interpretation, evaluation, and processing of a prescription drug order and includes those processes specified by the board in rule that are necessary for the preparation and provision of a drug to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient.

Subd. 31. **Central service pharmacy.** "Central service pharmacy" means a pharmacy that may provide dispensing functions, drug utilization review, packaging, labeling, or delivery of a prescription product to another pharmacy for the purpose of filling a prescription.

Subd. 32. **Electronic signature.** "Electronic signature" means an electronic sound, symbol, or process attached to or associated with a record and executed or adopted by a person with the intent to sign the record.

Subd. 33. **Electronic transmission.** "Electronic transmission" means transmission of information in electronic form.

Subd. 34. **Health professional shortage area.** "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. 35. **Compounding.** "Compounding" means preparing, mixing, assembling, packaging, and labeling a drug for an identified individual patient as a result of a practitioner's prescription drug order. Compounding also includes anticipatory compounding, as defined in this section, and the preparation of drugs in which all bulk drug substances and components are nonprescription substances. Compounding does not include mixing or reconstituting a drug according to the product's labeling or to the manufacturer's directions. Compounding does not include the preparation of a drug for the purpose of, or incident to, research, teaching, or chemical analysis, provided that the drug is not prepared for dispensing or administration to patients. All compounding, regardless

of the type of product, must be done pursuant to a prescription drug order unless otherwise permitted in this chapter or by the rules of the board.

Subd. 36. **Anticipatory compounding.** "Anticipatory compounding" means the preparation by a pharmacy of a supply of a compounded drug product that is sufficient to meet the short-term anticipated need of the pharmacy for the filling of prescription drug orders. In the case of practitioners only, anticipatory compounding means the preparation of a supply of a compounded drug product that is sufficient to meet the practitioner's short-term anticipated need for dispensing or administering the drug to patients treated by the practitioner. Anticipatory compounding is not the preparation of a compounded drug product for wholesale distribution.

Subd. 37. **Extemporaneous compounding.** "Extemporaneous compounding" means the compounding of a drug product pursuant to a prescription drug order for a specific patient that is issued in advance of the compounding. Extemporaneous compounding is not the preparation of a compounded drug product for wholesale distribution.

Subd. 38. **Compounded positron emission tomography drug.** "Compounded positron emission tomography drug" means a drug that:

(1) exhibits spontaneous disintegration of unstable nuclei by the emission of positrons and is used for the purpose of providing dual photon positron emission tomographic diagnostic images;

(2) has been compounded by or on the order of a practitioner in accordance with the relevant parts of Minnesota Rules, chapters 4731 and 6800, for a patient or for research, teaching, or quality control; and

(3) includes any nonradioactive reagent, reagent kit, ingredient, nuclide generator, accelerator, target material, electronic synthesizer, or other apparatus or computer program to be used in the preparation of such a drug.

Sec. 2. Minnesota Statutes 2012, section 151.06, is amended to read:

**151.06 POWERS AND DUTIES.**

Subdivision 1. **Generally; rules.** (a) Powers and duties. The Board of Pharmacy shall have the power and it shall be its duty:

(1) to regulate the practice of pharmacy;

(2) to regulate the manufacture, wholesale, and retail sale of drugs within this state;

(3) to regulate the identity, labeling, purity, and quality of all drugs and medicines dispensed in this state, using the United States Pharmacopeia and the National Formulary, or any revisions thereof, or standards adopted under the federal act as the standard;

(4) to enter and inspect by its authorized representative any and all places where drugs, medicines, medical gases, or veterinary drugs or devices are sold, vended, given away, compounded, dispensed, manufactured, wholesaled, or held; it may secure samples or specimens of any drugs, medicines, medical gases, or veterinary drugs or devices after paying or offering to pay for such sample; it shall be entitled to inspect and make copies of any and all records of shipment, purchase, manufacture, quality control, and sale of these items provided, however, that such inspection shall not extend to financial data, sales data, or pricing data;

(5) to examine and license as pharmacists all applicants whom it shall deem qualified to be such;

(6) to license wholesale drug distributors;

(7) to ~~deny, suspend, revoke, or refuse to renew~~ take disciplinary action against any registration or license required under this chapter~~, to any applicant or registrant or licensee~~ upon any of the ~~following~~ grounds~~:~~ listed in section 151.071, and in accordance with the provisions of section 151.071;

~~(i) fraud or deception in connection with the securing of such license or registration;~~

~~(ii) in the case of a pharmacist, conviction in any court of a felony;~~

~~(iii) in the case of a pharmacist, conviction in any court of an offense involving moral turpitude;~~

~~(iv) habitual indulgence in the use of narcotics, stimulants, or depressant drugs; or habitual indulgence in intoxicating liquors in a manner which could cause conduct endangering public health;~~

~~(v) unprofessional conduct or conduct endangering public health;~~

~~(vi) gross immorality;~~

~~(vii) employing, assisting, or enabling in any manner an unlicensed person to practice pharmacy;~~

~~(viii) conviction of theft of drugs, or the unauthorized use, possession, or sale thereof;~~

~~(ix) violation of any of the provisions of this chapter or any of the rules of the State Board of Pharmacy;~~

~~(x) in the case of a pharmacy license, operation of such pharmacy without a pharmacist present and on duty;~~

~~(xi) in the case of a pharmacist, physical or mental disability which could cause incompetency in the practice of pharmacy;~~

~~(xii) in the case of a pharmacist, the suspension or revocation of a license to practice pharmacy in another state; or~~

~~(xiii) in the case of a pharmacist, aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:~~

~~(A) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;~~

~~(B) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;~~

~~(C) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or~~

~~(D) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2;~~

(8) to employ necessary assistants and adopt rules for the conduct of its business;

(9) to register as pharmacy technicians all applicants who the board determines are qualified to carry out the duties of a pharmacy technician; ~~and~~

(10) to perform such other duties and exercise such other powers as the provisions of the act may require~~.~~; and

(11) to enter and inspect any business to which it issues a license or registration.

~~(b) Temporary suspension. In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend a license for not more than 60 days if the board finds that a pharmacist has violated a statute or rule that the board is empowered to enforce and continued practice by the pharmacist would create an imminent risk of harm to others. The suspension shall take effect upon written notice to the pharmacist, specifying the statute or rule violated. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held under the Administrative Procedure Act. The pharmacist shall be provided with at least 20 days' notice of any hearing held under this subdivision.~~

~~(c)~~ (b) Rules. For the purposes aforesaid, it shall be the duty of the board to make and publish uniform rules not inconsistent herewith for carrying out and enforcing the provisions of this chapter. The board shall adopt rules regarding prospective drug utilization review and patient counseling by pharmacists. A pharmacist in the exercise of the pharmacist's professional judgment, upon the presentation of a ~~new~~ prescription by a patient or the patient's caregiver or agent, shall perform the prospective drug utilization review required by rules issued under this subdivision.

~~(d)~~ (c) Substitution; rules. If the United States Food and Drug Administration (FDA) determines that the substitution of drugs used for the treatment of epilepsy or seizures poses a health risk to patients, the board shall adopt rules in accordance with accompanying FDA interchangeability standards regarding the use of substitution for

these drugs. If the board adopts a rule regarding the substitution of drugs used for the treatment of epilepsy or seizures that conflicts with the substitution requirements of section 151.21, subdivision 3, the rule shall supersede the conflicting statute. If the rule proposed by the board would increase state costs for state public health care programs, the board shall report to the chairs and ranking minority members of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division the proposed rule and the increased cost associated with the proposed rule before the board may adopt the rule.

Subd. 1a. ~~**Disciplinary action**~~ **Cease and desist orders.** ~~It shall be grounds for disciplinary action by the Board of Pharmacy against the registration of the pharmacy if the Board of Pharmacy determines that any person with supervisory responsibilities at the pharmacy sets policies that prevent a licensed pharmacist from providing drug utilization review and patient counseling as required by rules adopted under subdivision 1. The Board of Pharmacy shall follow the requirements of chapter 14 in any disciplinary actions taken under this section.~~ (a) Whenever it appears to the board that a person has engaged in an act or practice constituting a violation of a law, rule, or other order related to the duties and responsibilities entrusted to the board, the board may issue and cause to be served upon the person an order requiring the person to cease and desist from violations.

(b) The cease and desist order must state the reasons for the issuance of the order and must give reasonable notice of the rights of the person to request a hearing before an administrative law judge. A hearing must be held not later than ten days after the request for the hearing is received by the board. After the completion of the hearing, the administrative law judge shall issue a report within ten days. Within 15 days after receiving the report of the administrative law judge, the board shall issue a further order vacating or making permanent the cease and desist order. The time periods provided in this provision may be waived by agreement of the executive director of the board and the person against whom the cease and desist order was issued. If the person to whom a cease and desist order is issued fails to appear at the hearing after being duly notified, the person is in default, and the proceeding may be determined against that person upon consideration of the cease and desist order, the allegations of which may be considered to be true. Unless otherwise provided, all hearings must be conducted according to chapter 14. The board may adopt rules of procedure concerning all proceedings conducted under this subdivision.

(c) If no hearing is requested within 30 days of service of the order, the cease and desist order will become permanent.

(d) A cease and desist order issued under this subdivision remains in effect until it is modified or vacated by the board. The administrative proceeding provided by this

subdivision, and subsequent appellate judicial review of that administrative proceeding, constitutes the exclusive remedy for determining whether the board properly issued the cease and desist order and whether the cease and desist order should be vacated or made permanent.

Subd. 1b. **Enforcement of violations of cease and desist orders.** (a) Whenever the board under subdivision 1a seeks to enforce compliance with a cease and desist order that has been made permanent, the allegations of the cease and desist order are considered conclusively established for purposes of proceeding under subdivision 1a for permanent or temporary relief to enforce the cease and desist order. Whenever the board under subdivision 1a seeks to enforce compliance with a cease and desist order when a hearing or hearing request on the cease and desist order is pending, or the time has not yet expired to request a hearing on whether a cease and desist order should be vacated or made permanent, the allegations in the cease and desist order are considered conclusively established for the purposes of proceeding under subdivision 1a for temporary relief to enforce the cease and desist order.

(b) Notwithstanding this subdivision or subdivision 1a, the person against whom the cease and desist order is issued and who has requested a hearing under subdivision 1a may, within 15 days after service of the cease and desist order, bring an action in Ramsey County District Court for issuance of an injunction to suspend enforcement of the cease and desist order pending a final decision of the board under subdivision 1a to vacate or make permanent the cease and desist order. The court shall determine whether to issue such an injunction based on traditional principles of temporary relief.

Subd. 2. **Application.** In the case of a facility licensed or registered by the board, the provisions of subdivision 1 shall apply to an individual owner or sole proprietor and shall also apply to the following:

(1) In the case of a partnership, each partner thereof;

(2) In the case of an association, each member thereof;

(3) In the case of a corporation, each officer or director thereof and each shareholder owning 30 percent or more of the voting stock of such corporation.

~~Subd. 3. **Application of Administrative Procedure Act.** The board shall comply with the provisions of chapter 14, before it fails to issue, renew, suspends, or revokes any license or registration issued under this chapter.~~

~~Subd. 4. **Reinstatement.** Any license or registration which has been suspended or revoked may be reinstated by the board provided the holder thereof shall pay all costs of the proceedings resulting in the suspension or revocation, and, in addition thereto, pay a fee set by the board.~~

~~Subd. 5. **Costs; penalties.** The board may impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including, but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.~~

Sec. 3. **[151.071] DISCIPLINARY ACTION.**

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such

adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas distributor, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients or the dispensing of drugs or devices;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; and

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professional services program for reasons other than the satisfactory completion of the program.

Subd. 3. **Automatic suspension.** (a) A license or registration issued under this chapter to a pharmacist, pharmacist intern, pharmacy technician, or controlled substance researcher is automatically suspended if: (1) a guardian of a licensee or registrant is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the licensee or registrant; or (2) the licensee or registrant is committed by order of a court pursuant to chapter 253B. The license or registration remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee or registrant, the suspension is terminated by the board after a hearing.

(b) For a pharmacist, pharmacy intern, or pharmacy technician, upon notice to the board of a judgment of, or a plea of guilty to, a felony reasonably related to the practice of pharmacy, the license or registration of the regulated person may be automatically suspended by the board. The license or registration will remain suspended until, upon petition by the regulated individual and after a hearing, the suspension is terminated by the board. The board may indefinitely suspend or revoke the license or registration of the

regulated individual if, after a hearing before the board, the board finds that the felonious conduct would cause a serious risk of harm to the public.

(c) For a facility that is licensed or registered by the board, upon notice to the board that an owner of the facility is subject to a judgment of, or a plea of guilty to, a felony reasonably related to the operation of the facility, the license or registration of the facility may be automatically suspended by the board. The license or registration will remain suspended until, upon petition by the facility and after a hearing, the suspension is terminated by the board. The board may indefinitely suspend or revoke the license or registration of the facility if, after a hearing before the board, the board finds that the felonious conduct would cause a serious risk of harm to the public.

(d) For licenses and registrations that have been suspended or revoked pursuant to paragraphs (a) and (b), the regulated individual may have a license or registration reinstated, either with or without restrictions, by demonstrating clear and convincing evidence of rehabilitation, as provided in section 364.03. If the regulated individual has the conviction subsequently overturned by court decision, the board shall conduct a hearing to review the suspension within 30 days after the receipt of the court decision. The regulated individual is not required to prove rehabilitation if the subsequent court decision overturns previous court findings of public risk.

(e) For licenses and registrations that have been suspended or revoked pursuant to paragraph (c), the regulated facility may have a license or registration reinstated, either with or without restrictions, conditions, or limitations, by demonstrating clear and convincing evidence of rehabilitation of the convicted owner, as provided in section 364.03. If the convicted owner has the conviction subsequently overturned by court decision, the board shall conduct a hearing to review the suspension within 30 days after receipt of the court decision. The regulated facility is not required to prove rehabilitation of the convicted owner if the subsequent court decision overturns previous court findings of public risk.

(f) The board may, upon majority vote of a quorum of its appointed members, suspend the license or registration of a regulated individual without a hearing if the regulated individual fails to maintain a current name and address with the board, as described in paragraphs (h) and (i), while the regulated individual is: (1) under board investigation, and a notice of conference has been issued by the board; (2) party to a contested case with the board; (3) party to an agreement for corrective action with the board; or (4) under a board order for disciplinary action. The suspension shall remain in effect until lifted by the board to the board's receipt of a petition from the regulated individual, along with the current name and address of the regulated individual.

(g) The board may, upon majority vote of a quorum of its appointed members, suspend the license or registration of a regulated facility without a hearing if the regulated facility fails to maintain a current name and address of the owner of the facility with the board, as described in paragraphs (h) and (i), while the regulated facility is: (1) under board investigation, and a notice of conference has been issued by the board; (2) party to a contested case with the board; (3) party to an agreement for corrective action with the board; or (4) under a board order for disciplinary action. The suspension shall remain in effect until lifted by the board pursuant to the board's receipt of a petition from the regulated facility, along with the current name and address of the owner of the facility.

(h) An individual licensed or registered by the board shall maintain a current name and home address with the board and shall notify the board in writing within 30 days of any change in name or home address. An individual regulated by the board shall also maintain a current business address with the board as required by section 214.073. For an individual, if a name change only is requested, the regulated individual must request a revised license or registration. The board may require the individual to substantiate the name change by submitting official documentation from a court of law or agency authorized under law to receive and officially record a name change. In the case of an individual, if an address change only is requested, no request for a revised license or registration is required. If the current license or registration of an individual has been lost, stolen, or destroyed, the individual shall provide a written explanation to the board.

(i) A facility licensed or registered by the board shall maintain a current name and address with the board. A facility shall notify the board in writing within 30 days of any change in name. A facility licensed or registered by the board but located outside of the state must notify the board within 30 days of an address change. A facility licensed or registered by the board and located within the state must notify the board at least 60 days in advance of a change of address that will result from the move of the facility to a different location and must pass an inspection at the new location as required by the board. If the current license or registration of a facility has been lost, stolen, or destroyed, the facility shall provide a written explanation to the board.

Subd. 4. **Effective dates.** A suspension, revocation, condition, limitation, qualification, or restriction of a license or registration shall be in effect pending determination of an appeal.

Subd. 5. **Conditions on reissued license.** In its discretion, the board may restore and reissue a license or registration issued under this chapter, but as a condition thereof may impose any disciplinary or corrective measure that it might originally have imposed.

Subd. 6. **Temporary suspension of license for pharmacists.** In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a pharmacist if the board finds that the pharmacist has violated a statute or rule that the board is empowered to enforce and continued practice by the pharmacist would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the pharmacist, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The pharmacist shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Subd. 7. **Temporary suspension of license for pharmacist interns, pharmacy technicians, and controlled substance researchers.** In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the registration of a pharmacist intern, pharmacy technician, or controlled substance researcher if the board finds that the registrant has violated a statute or rule that the board is empowered to enforce and continued registration of the registrant would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the registrant, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The licensee or registrant shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Subd. 8. **Temporary suspension of license for pharmacies, drug wholesalers, drug manufacturers, medical gas manufacturers, and medical gas distributors.** In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license or registration of a pharmacy, drug wholesaler, drug manufacturer, medical gas manufacturer, or medical gas distributor if the board finds that the licensee or registrant has violated a statute or rule that the board is empowered to enforce and continued operation of the licensed facility would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the licensee or registrant, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The licensee or registrant shall be provided with at

least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Subd. 9. **Evidence.** In disciplinary actions alleging a violation of subdivision 2, clause (4), (5), (6), or (7), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of the contents thereof.

Subd. 10. **Mental examination; access to medical data.** If the board has probable cause to believe that an individual licensed or registered by the board falls under subdivision 2, clause (14), it may direct the individual to submit to a mental or physical examination. For the purpose of this subdivision, every licensed or registered individual is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining practitioner's testimony or examination reports on the grounds that the same constitute a privileged communication. Failure of a licensed or registered individual to submit to an examination when directed constitutes an admission of the allegations against the individual, unless the failure was due to circumstances beyond the individual's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. Pharmacists affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that they can resume the competent practice of the profession of pharmacy with reasonable skill and safety to the public. Pharmacist interns, pharmacy technicians, or controlled substance researchers affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that they can competently resume the duties that can be performed, under this chapter or the rules of the board, by similarly registered persons with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a licensed or registered individual in any other proceeding.

Subd. 11. **Tax clearance certificate.** (a) In addition to the provisions of subdivision 1, the board may not issue or renew a license or registration if the commissioner of revenue notifies the board and the licensee or applicant for a license that the licensee or applicant owes the state delinquent taxes in the amount of $500 or more. The board may issue or renew the license or registration only if (1) the commissioner of revenue issues a tax clearance certificate, and (2) the commissioner of revenue or the licensee, registrant, or applicant forwards a copy of the clearance to the board. The commissioner of revenue

may issue a clearance certificate only if the licensee, registrant, or applicant does not owe the state any uncontested delinquent taxes.

(b) For purposes of this subdivision, the following terms have the meanings given.

(1) "Taxes" are all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes.

(2) "Delinquent taxes" do not include a tax liability if (i) an administrative or court action that contests the amount or validity of the liability has been filed or served, (ii) the appeal period to contest the tax liability has not expired, or (iii) the licensee or applicant has entered into a payment agreement to pay the liability and is current with the payments.

(c) In lieu of the notice and hearing requirements of subdivision 1, when a licensee, registrant, or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the licensee or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice provided in paragraph (a). The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the Office of Administrative Hearings. Notwithstanding any law to the contrary, the licensee or applicant must be served with 20 days' notice in writing specifying the time and place of the hearing and the allegations against the licensee or applicant. The notice may be served personally or by mail.

(d) A licensee or applicant must provide the licensee's or applicant's Social Security number and Minnesota business identification number on all license applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all licensees and applicants that includes the licensee's or applicant's name, address, Social Security number, and business identification number. The commissioner of revenue may request a list of the licensees and applicants no more than once each calendar year.

Subd. 12. **Limitation.** No board proceeding against a regulated person or facility shall be instituted unless commenced within seven years from the date of the commission of some portion of the offense or misconduct complained of except for alleged violations of subdivision 2, clause (21).

Sec. 4. **[151.072] REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under the provisions of this chapter or the rules of the board may report the violation to the board.

Subd. 2. **Pharmacies.** A pharmacy located in this state must report to the board any discipline that is related to an incident involving conduct that would constitute grounds

for discipline under the provisions of this chapter or the rules of the board, that is taken by the pharmacy or any of its administrators against a pharmacist, pharmacist intern, or pharmacy technician, including the termination of employment of the individual or the revocation, suspension, restriction, limitation, or conditioning of an individual's ability to practice or work at or on behalf of the pharmacy. The pharmacy shall also report the resignation of any pharmacist, pharmacist intern, or technician prior to the conclusion of any disciplinary proceeding, or prior to the commencement of formal charges but after the individual had knowledge that formal charges were contemplated or in preparation. Each report made under this subdivision must state the nature of the action taken and state in detail the reasons for the action. Failure to report violations as required by this subdivision is a basis for discipline pursuant to section 151.071, subdivision 2, clause (8).

Subd. 3. **Licensees and registrants of the board.** A licensee or registrant of the board shall report to the board personal knowledge of any conduct that the person reasonably believes constitutes grounds for disciplinary action under this chapter or the rules of the board by any pharmacist, pharmacist intern, pharmacy technician, or controlled substance researcher, including any conduct indicating that the person may be professionally incompetent, or may have engaged in unprofessional conduct or may be medically or physically unable to engage safely in the practice of pharmacy or to carry out the duties permitted to the person by this chapter or the rules of the board. Failure to report violations as required by this subdivision is a basis for discipline pursuant to section 151.071, subdivision 2, clause (20).

Subd. 4. **Courts.** The court administrator of a district court or any other court of competent jurisdiction shall report to the board any judgment or other determination of the court that: adjudges or includes a finding that a licensee or registrant of the board is mentally ill, mentally incompetent, guilty of a felony, or guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of an abuse or fraud under Medicare or Medicaid; appoints a guardian of the licensee or registrant pursuant to sections 524.5-101 to 524.5-502; or commits a licensee or registrant pursuant to chapter 253B.

Subd. 5. **Self-reporting.** A licensee or registrant of the board shall report to the board any personal action that would require that a report be filed with the board pursuant to subdivision 2 or 4.

Subd. 6. **Deadlines; forms.** Reports required by subdivisions 2 to 5 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Subd. 7. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 5 or any related documents.

Sec. 5. **[151.073] IMMUNITY.**

Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting in good faith a report to the board under section 151.072 or for otherwise reporting in good faith to the board violations or alleged violations of this chapter or the rules of the board. All such reports are investigative data pursuant to chapter 13.

Sec. 6. **[151.074] LICENSEE OR REGISTRANT COOPERATION.**

An individual who is licensed or registered by the board, who is the subject of an investigation by or on behalf of the board, shall cooperate fully with the investigation. An owner or employee of a facility that is licensed or registered by the board, when the facility is the subject of an investigation by or on behalf of the board, shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by, or on behalf of, the board relating to the subject of the investigation and providing copies of patient pharmacy records and other relevant records, as reasonably requested by the board, to assist the board in its investigation. The board shall maintain any records obtained pursuant to this section as investigative data pursuant to chapter 13.

Sec. 7. **[151.075] DISCIPLINARY RECORD ON JUDICIAL REVIEW.**

Upon judicial review of any board disciplinary action taken under this chapter, the reviewing court shall seal the administrative record, except for the board's final decision, and shall not make the administrative record available to the public.

Sec. 8. Minnesota Statutes 2012, section 151.211, is amended to read:

**151.211 RECORDS OF PRESCRIPTIONS.**

Subdivision 1. **Retention of prescription drug orders.** All ~~prescriptions dispensed~~ prescription drug orders shall be kept on file at the location ~~in~~ from which ~~such~~ dispensing ~~occurred~~ of the ordered drug occurs for a period of at least two years. Prescription drug orders that are electronically prescribed must be kept on file in the format in which they were originally received. Written or printed prescription drug orders and verbal prescription drug orders reduced to writing, must be kept on file as received or transcribed, except that such orders may be kept in an electronic format as allowed by the board. Electronic systems used to process and store prescription drug orders must be compliant

with the requirements of this chapter and the rules of the board. Prescription drug orders that are stored in an electronic format, as permitted by this subdivision, may be kept on file at a remote location provided that they are readily and securely accessible from the location at which dispensing of the ordered drug occurred.

Subd. 2. **Refill requirements.** ~~No~~ A prescription ~~shall~~ drug order may be refilled ~~except~~ only with the written, electronic, or verbal consent of the prescriber and in accordance with the requirements of this chapter, the rules of the board, and where applicable, section 152.11. The date of such refill must be recorded and initialed upon the original prescription drug order, or within the electronically maintained record of the original prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the prescription.

Sec. 9. **[151.251] COMPOUNDING.**

Subdivision 1. **Exemption from manufacturing licensure requirement.** Section 151.252 shall not apply to:

(1) a practitioner engaged in extemporaneous compounding, anticipatory compounding, or compounding not done pursuant to a prescription drug order when permitted by this chapter or the rules of the board; and

(2) a pharmacy in which a pharmacist is engaged in extemporaneous compounding, anticipatory compounding, or compounding not done pursuant to a prescription drug order when permitted by this chapter or the rules of the board.

Subd. 2. **Compounded drug.** A drug product may be compounded under this section if a pharmacist or practitioner:

(a) compounds the drug product using bulk drug substances, as defined in the federal regulations published in Code of Federal Regulations, title 21, section 207.3(a)(4):

(1) that:

(i) comply with the standards of an applicable United States Pharmacopoeia or National Formulary monograph, if a monograph exists, and the United States Pharmacopoeia chapter on pharmacy compounding;

(ii) if such a monograph does not exist, are drug substances that are components of drugs approved for use in this country by the United States Food and Drug Administration; or

(iii) if such a monograph does not exist and the drug substance is not a component of a drug approved for use in this country by the United States Food and Drug Administration, that appear on a list developed by the United States Food and Drug Administration through

regulations issued by the secretary of the federal Department of Health and Human Services pursuant to section 503a of the Food, Drug and Cosmetic Act under paragraph (d);

(2) that are manufactured by an establishment that is registered under section 360 of the federal Food, Drug and Cosmetic Act, including a foreign establishment that is registered under section 360(i) of that act; and

(3) that are accompanied by valid certificates of analysis for each bulk drug substance;

(b) compounds the drug product using ingredients, other than bulk drug substances, that comply with the standards of an applicable United States Pharmacopoeia or National Formulary monograph, if a monograph exists, and the United States Pharmacopoeia chapters on pharmacy compounding;

(c) does not compound a drug product that appears on a list published by the secretary of the federal Department of Health and Human Services in the Federal Register of drug products that have been withdrawn or removed from the market because such drug products or components of such drug products have been found to be unsafe or not effective;

(d) does not compound any drug products that are essentially copies of a commercially available drug product; and

(e) does not compound any drug product that has been identified pursuant to United States Code, title 21, section 353a, as a drug product that presents demonstrable difficulties for compounding that reasonably demonstrate an adverse effect on the safety or effectiveness of that drug product.

The term "essentially a copy of a commercially available drug product" does not include a drug product in which there is a change, made for an identified individual patient, that produces for that patient a significant difference, as determined by the prescribing practitioner, between the compounded drug and the comparable commercially available drug product.

Subd. 3. **Exceptions.** This section shall not apply to:

(1) compounded positron emission tomography drugs as defined in section 151.01, subdivision 38; or

(2) radiopharmaceuticals.

Sec. 10. Minnesota Statutes 2013 Supplement, section 151.252, is amended by adding a subdivision to read:

Subd. 1a. **Outsourcing facility.** (a) No person shall act as an outsourcing facility without first obtaining a license from the board and paying any applicable manufacturer licensing fee specified in section 151.065.

(b) Application for an outsourcing facility license under this section shall be made in a manner specified by the board and may differ from the application required of other drug manufacturers.

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

(d) No license shall be issued or renewed for an outsourcing facility unless the applicant supplies the board with proof of such registration by the United States Food and Drug Administration as required by United States Code, title 21, section 353b.

(e) No license shall be issued or renewed for an outsourcing facility 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 such licensure or registration. The board may establish, by rule, standards for the licensure of an outsourcing facility 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 outsourcing facility located within the state and for each outsourcing facility located outside of the state at which drugs that are shipped into the state are prepared.

(g) The board shall not issue an initial or renewed license for an outsourcing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of an outsourcing 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.

Sec. 11. Minnesota Statutes 2012, section 151.26, is amended to read:

**151.26 EXCEPTIONS.**

Subdivision 1. **Generally.** Nothing in this chapter shall subject a person duly licensed in this state to practice medicine, dentistry, or veterinary medicine, to inspection by the State Board of Pharmacy, nor prevent the person from administering drugs, medicines, chemicals, or poisons in the person's practice, nor prevent a duly licensed practitioner from furnishing to a patient properly packaged and labeled drugs, medicines, chemicals, or poisons as may be considered appropriate in the treatment of such patient;

unless the person is engaged in the dispensing, sale, or distribution of drugs and the board provides reasonable notice of an inspection.

Except for the provisions of section 151.37, nothing in this chapter applies to or interferes with the dispensing, in its original package and at no charge to the patient, of a legend drug, other than a controlled substance, that was packaged by a manufacturer and provided to the dispenser for distribution as a professional sample.

Nothing in this chapter shall prevent the sale of drugs, medicines, chemicals, or poisons at wholesale to licensed physicians, dentists and veterinarians for use in their practice, nor to hospitals for use therein.

Nothing in this chapter shall prevent the sale of drugs, chemicals, or poisons either at wholesale or retail for use for commercial purposes, or in the arts, nor interfere with the sale of insecticides, as defined in Minnesota Statutes 1974, section 24.069, and nothing in this chapter shall prevent the sale of common household preparations and other drugs, chemicals, and poisons sold exclusively for use for nonmedicinal purposes~~.~~; provided that this exception does not apply to any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted for human consumption under Minnesota law that, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance listed in section 152.02, subdivisions 2 and 3, or Minnesota Rules, parts 6800.4210 and 6800.4220, regardless of whether the substance is marketed for the purpose of human consumption.

Nothing in this chapter shall apply to or interfere with the vending or retailing of any nonprescription medicine or drug not otherwise prohibited by statute ~~which~~ that is prepackaged, fully prepared by the manufacturer or producer for use by the consumer, and labeled in accordance with the requirements of the state or federal Food and Drug Act; nor to the manufacture, wholesaling, vending, or retailing of flavoring extracts, toilet articles, cosmetics, perfumes, spices, and other commonly used household articles of a chemical nature, for use for nonmedicinal purposes~~.~~; provided that this exception does not apply to any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted for human consumption under Minnesota law that, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance listed in section 152.02, subdivisions 2 and 3, or Minnesota Rules, parts 6800.4210 and 6800.4220, regardless of whether the substance is marketed for the purpose of human consumption. Nothing in this chapter shall prevent the sale of drugs or medicines by licensed pharmacists at a discount to persons over 65 years of age.

Sec. 12. Minnesota Statutes 2012, section 151.34, is amended to read:

**151.34 PROHIBITED ACTS.**

It shall be unlawful to:

(1) manufacture, sell or deliver, hold or offer for sale any drug that is adulterated or misbranded;

(2) adulterate or misbrand any drug;

(3) receive in commerce any drug that is adulterated or misbranded, and to deliver or proffer delivery thereof for pay or otherwise;

(4) refuse to permit entry or inspection, or to permit the taking of a sample, or to permit access to or copying of any record as authorized by this chapter;

(5) remove or dispose of a detained or embargoed article in violation of this chapter;

(6) alter, mutilate, destroy, obliterate, or remove the whole or any part of the labeling of, or to do any other act with respect to a drug, if such act is done while such drug is held for sale and results in such drug being adulterated or misbranded;

(7) use for a person's own advantage or to reveal other than to the board or its authorized representative or to the courts when required in any judicial proceeding under this chapter any information acquired under authority of this chapter concerning any method or process ~~which~~ that is a trade secret and entitled to protection;

(8) use on the labeling of any drug any representation or suggestion that an application with respect to such drug is effective under the federal act or that such drug complies with such provisions;

(9) in the case of a manufacturer, packer, or distributor offering legend drugs for sale within this state, fail to maintain for transmittal or to transmit, to any practitioner licensed by applicable law to administer such drug who makes written request for information as to such drug, true and correct copies of all printed matter ~~which~~ that is required to be included in any package in which that drug is distributed or sold, or such other printed matter as is approved under the federal act. Nothing in this paragraph shall be construed to exempt any person from any labeling requirement imposed by or under provisions of this chapter;

(10) conduct a pharmacy without a pharmacist in charge;

(11) dispense a legend drug without first obtaining a valid prescription for that drug;

(12) conduct a pharmacy without proper registration with the board;

(13) practice pharmacy without being licensed to do so by the board; ~~or~~

(14) sell at retail federally restricted medical gases without proper registration with the board except as provided in this chapter~~.~~; or

(15) sell any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted

for human consumption under Minnesota law that, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance listed in section 152.02, subdivisions 2 and 3, or Minnesota Rules, parts 6800.4210 and 6800.4220, regardless of whether the substance is marketed for the purpose of human consumption.

Sec. 13. Minnesota Statutes 2012, section 151.35, is amended to read:

**151.35 DRUGS, ADULTERATION.**

A drug shall be deemed to be adulterated:

(1) if it consists in whole or in part of any filthy, putrid or decomposed substance; or if it has been produced, prepared, packed, or held under unsanitary conditions whereby it may have been rendered injurious to health, or whereby it may have been contaminated with filth; or if the methods used in, or the facilities or controls used for, its manufacture, processing, packing, or holding do not conform to or are not operated or administered in conformity with current good manufacturing practice as required under the federal act to assure that such drug is safe and has the identity, strength, quality, and purity characteristics, which it purports or is represented to possess; or the facility in which it was produced was not registered by the United States Food and Drug Administration or licensed by the board; or, its container is composed, in whole or in part, of any poisonous or deleterious substance which may render the contents injurious to health; or it bears or contains, for purposes of coloring only, a color additive which is unsafe within the meaning of the federal act, or it is a color additive, the intended use of which in or on drugs is for the purposes of coloring only, and is unsafe within the meaning of the federal act;

(2) if it purports to be or is represented as a drug the name of which is recognized in the United States Pharmacopoeia or the National Formulary, and its strength differs from, or its quality or purity falls below, the standard set forth therein. Such determination as to strength, quality, or purity shall be made in accordance with the tests or methods of assay set forth in such compendium, or in the absence of or inadequacy of such tests or methods of assay, those prescribed under authority of the federal act. No drug defined in the United States Pharmacopoeia or the National Formulary shall be deemed to be adulterated under this paragraph because it differs from the standard of strength, quality, or purity therefor set forth in such compendium, if its difference in strength, quality, or purity from such standard is plainly stated on its label;

(3) if it is not subject to the provisions of paragraph (2) of this section and its strength differs from, or its purity or quality differs from that which it purports or is represented to possess;

(4) if any substance has been mixed or packed therewith so as to reduce its quality or strength, or substituted wholly or in part therefor.

Sec. 14. Minnesota Statutes 2012, section 151.361, subdivision 2, is amended to read:

Subd. 2. **After January 1, 1983.** (a) No legend drug in solid oral dosage form may be manufactured, packaged or distributed for sale in this state after January 1, 1983 unless it is clearly marked or imprinted with a symbol, number, company name, words, letters, national drug code or other mark uniquely identifiable to that drug product. An identifying mark or imprint made as required by federal law or by the federal Food and Drug Administration shall be deemed to be in compliance with this section.

(b) The Board of Pharmacy may grant exemptions from the requirements of this section on its own initiative or upon application of a manufacturer, packager, or distributor indicating size or other characteristics ~~which~~ that render the product impractical for the imprinting required by this section.

~~(c) The provisions of clauses (a) and (b) shall not apply to any of the following:~~

~~(1) Drugs purchased by a pharmacy, pharmacist, or licensed wholesaler prior to January 1, 1983, and held in stock for resale.~~

~~(2) Drugs which are manufactured by or upon the order of a practitioner licensed by law to prescribe or administer drugs and which are to be used solely by the patient for whom prescribed.~~

Sec. 15. Minnesota Statutes 2012, section 151.37, as amended by Laws 2013, chapter 43, section 30, Laws 2013, chapter 55, section 2, and Laws 2013, chapter 108, article 10, section 5, is amended to read:

**151.37 LEGEND DRUGS, WHO MAY PRESCRIBE, POSSESS.**

Subdivision 1. **Prohibition.** Except as otherwise provided in this chapter, it shall be unlawful for any person to have in possession, or to sell, give away, barter, exchange, or distribute a legend drug.

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 licensed dietitian or

licensed nutritionist, pursuant to section 148.634; 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~~ drug 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, if not a licensed practitioner, a designee of 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.

Subd. 2a. **Delegation.** A supervising physician may delegate to a physician assistant who is registered with the Board of Medical Practice and certified by the National Commission on Certification of Physician Assistants and who is under the supervising physician's supervision, the authority to prescribe, dispense, and administer legend drugs and medical devices, subject to the requirements in chapter 147A and other requirements established by the Board of Medical Practice in rules.

Subd. 3. **Veterinarians.** A licensed doctor of veterinary medicine, in the course of professional practice only and not for use by a human being, may personally prescribe, administer, and dispense a legend drug, and may cause the same to be administered or dispensed by an assistant under the doctor's direction and supervision.

Subd. 4. **Research.** (a) Any qualified person may use legend drugs in the course of a bona fide research project, but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed, and administered by a person lawfully authorized to do so.

(b) Drugs may be dispensed or distributed by a pharmacy licensed by the board for use by, or administration to, patients enrolled in a bona fide research study that is being conducted pursuant to either an investigational new drug application approved by the United States Food and Drug Administration or that has been approved by an institutional review board. For the purposes of this subdivision only:

(1) a prescription drug order is not required for a pharmacy to dispense a research drug, unless the study protocol requires the pharmacy to receive such an order;

(2) notwithstanding the prescription labeling requirements found in this chapter or the rules promulgated by the board, a research drug may be labeled as required by the study protocol; ~~and~~

(3) dispensing and distribution of research drugs by pharmacies shall not be considered ~~compounding,~~ manufacturing~~,~~ or wholesaling under this chapter~~.~~; and

(4) a pharmacy may compound drugs for research studies as provided in this subdivision but must follow applicable standards established by United States Pharmacopeia, chapter 795 or 797, for nonsterile and sterile compounding, respectively.

(c) An entity that is under contract to a federal agency for the purpose of distributing drugs for bona fide research studies is exempt from the drug wholesaler licensing requirements of this chapter. Any other entity is exempt from the drug wholesaler licensing requirements of this chapter if the board finds that the entity is licensed or registered according to the laws of the state in which it is physically located and it is distributing drugs for use by, or administration to, patients enrolled in a bona fide research study that is being conducted pursuant to either an investigational new drug application approved by the United States Food and Drug Administration or that has been approved by an institutional review board.

Subd. 5. **Exclusion for course of practice.** Nothing in this chapter shall prohibit the sale to, or the possession of, a legend drug by licensed drug wholesalers, licensed manufacturers, registered pharmacies, local detoxification centers, licensed hospitals, bona fide hospitals wherein animals are treated, or licensed pharmacists and licensed practitioners while acting within the course of their practice only.

Subd. 6. **Exclusion for course of employment.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by an employee, agent, or sales representative of a registered drug manufacturer, or an employee or agent of a registered drug wholesaler, or registered pharmacy, while acting in the course of employment.

(b) Nothing in this chapter shall prohibit the following entities from possessing a legend drug for the purpose of disposing of the legend drug as pharmaceutical waste:

(1) a law enforcement officer;

(2) a hazardous waste transporter licensed by the Department of Transportation;

(3) a facility permitted by the Pollution Control Agency to treat, store, or dispose of hazardous waste, including household hazardous waste;

(4) a facility licensed by the Pollution Control Agency or a metropolitan county as a very small quantity generator collection program or a minimal generator;

(5) a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or a person authorized by the county to conduct one or more of these activities; or

(6) a sanitary district organized under chapter 115, or a special law.

Subd. 7. **Exclusion for prescriptions.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by a person for that person's use when it has been dispensed to the person in accordance with a valid prescription issued by a practitioner.

(b) Nothing in this chapter shall prohibit a person, for whom a legend drug has been dispensed in accordance with a written or oral prescription by a practitioner, from designating a family member, caregiver, or other individual to handle the legend drug for the purpose of assisting the person in obtaining or administering the drug or sending the drug for destruction.

(c) Nothing in this chapter shall prohibit a person for whom a prescription drug has been dispensed in accordance with a valid prescription issued by a practitioner from transferring the legend drug to a county that collects, stores, transports, or disposes of a legend drug pursuant to a program in compliance with applicable federal law or to a person authorized by the county to conduct one or more of these activities.

Subd. 8. **Misrepresentation.** It is unlawful for a person to procure, attempt to procure, possess, or control a legend drug by any of the following means:

(1) deceit, misrepresentation, or subterfuge;

(2) using a false name; or

(3) falsely assuming the title of, or falsely representing a person to be a manufacturer, wholesaler, pharmacist, practitioner, or other authorized person for the purpose of obtaining a legend drug.

Subd. 9. **Exclusion for course of laboratory employment.** Nothing in this chapter shall prohibit the possession of a legend drug by an employee or agent of a registered analytical laboratory while acting in the course of laboratory employment.

Subd. 10. **Purchase of drugs and other agents by commissioner of health.** The commissioner of health, in preparation for and in carrying out the duties of sections 144.05, 144.4197, and 144.4198, may purchase, store, and distribute antituberculosis drugs, biologics, vaccines, antitoxins, serums, immunizing agents, antibiotics, antivirals, antidotes, other pharmaceutical agents, and medical supplies to treat and prevent communicable disease.

Subd. 10a. **Emergency use authorizations.** Nothing in this chapter shall prohibit the purchase, possession, or use of a legend drug by an entity acting according to an emergency use authorization issued by the United States Food and Drug Administration

pursuant to United States Code, title 21, section 360.bbb-3. The entity must be specifically tasked in a public health response plan to perform critical functions necessary to support the response to a public health incident or event.

Subd. 11. ~~**Complaint reporting**~~ **Exclusion for health care educational programs.** ~~The Board of Pharmacy shall report on a quarterly basis to the Board of Optometry any complaints received regarding the prescription or administration of legend drugs under section 148.576.~~ Nothing in this section shall prohibit an accredited public or private postsecondary school from possessing a legend drug that is not a controlled substance listed in section 152.02, provided that:

(a) the school is approved by the United States secretary of education in accordance with requirements of the Higher Education Act of 1965, as amended;

(b) the school provides a course of instruction that prepares individuals for employment in a health care occupation or profession;

(c) the school may only possess those drugs necessary for the instruction of such individuals; and

(d) the drugs may only be used in the course of providing such instruction and are labeled by the purchaser to indicate that they are not to be administered to patients.

Those areas of the school in which legend drugs are stored are subject to section 151.06, subdivision 1, paragraph (a), clause (4).

Sec. 16. Minnesota Statutes 2012, section 151.44, is amended to read:

**151.44 DEFINITIONS.**

As used in sections 151.43 to 151.51, the following terms have the meanings given in paragraphs (a) to (h):

(a) "Wholesale drug distribution" means distribution of prescription or nonprescription drugs to persons other than a consumer or patient or reverse distribution of such drugs, but does not include:

(1) a sale between a division, subsidiary, parent, affiliated, or related company under the common ownership and control of a corporate entity;

(2) the purchase or other acquisition, by a hospital or other health care entity that is a member of a group purchasing organization, of a drug for its own use from the organization or from other hospitals or health care entities that are members of such organizations;

(3) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in section 501(c)(3) of the Internal Revenue Code of 1986, as amended through December 31, 1988, to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(4) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug among hospitals or other health care entities that are under common control;

(5) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug for emergency medical reasons;

(6) the sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription;

(7) the transfer of prescription or nonprescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage;

(8) the distribution of prescription or nonprescription drug samples by manufacturers representatives; or

(9) the sale, purchase, or trade of blood and blood components.

(b) "Wholesale drug distributor" means anyone engaged in wholesale drug distribution including, but not limited to, manufacturers; ~~repackers~~ repackagers; own-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and pharmacies that conduct wholesale drug distribution. A wholesale drug distributor does not include a common carrier or individual hired primarily to transport prescription or nonprescription drugs.

(c) "Manufacturer" ~~means anyone who is engaged in the manufacturing, preparing, propagating, compounding, processing, packaging, repackaging, or labeling of a prescription drug~~ has the meaning provided in section 151.01, subdivision 14b.

(d) "Prescription drug" means a drug required by federal or state law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to United States Code, title 21, sections 811 and 812.

(e) "Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

(f) "Blood components" means that part of blood separated by physical or mechanical means.

(g) "Reverse distribution" means the receipt of prescription or nonprescription drugs received from or shipped to Minnesota locations for the purpose of returning the drugs to their producers or distributors.

(h) "Reverse distributor" means a person engaged in the reverse distribution of drugs.

Sec. 17. Minnesota Statutes 2012, section 151.58, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section only, the terms defined in this subdivision have the meanings given.

(a) "Automated drug distribution system" or "system" means a mechanical system approved by the board that performs operations or activities, other than compounding or administration, related to the storage, packaging, or dispensing of drugs, and collects, controls, and maintains all required transaction information and records.

(b) "Health care facility" means a nursing home licensed under section 144A.02; a housing with services establishment registered under section 144D.01, subdivision 4, in which a home provider licensed under chapter 144A is providing centralized storage of medications; or a ~~community behavioral health hospital or~~ Minnesota sex offender program facility operated by the Department of Human Services.

(c) "Managing pharmacy" means a pharmacy licensed by the board that controls and is responsible for the operation of an automated drug distribution system.

Sec. 18. Minnesota Statutes 2012, section 151.58, subdivision 3, is amended to read:

Subd. 3. **Authorization.** A pharmacy may use an automated drug distribution system to fill prescription drug orders for patients of a health care facility provided that the policies and procedures required by this section have been approved by the board. The automated drug distribution system may be located in a health care facility that is not at the same location as the managing pharmacy. When located within a health care facility, the system is considered to be an extension of the managing pharmacy.

Sec. 19. Minnesota Statutes 2012, section 151.58, subdivision 5, is amended to read:

Subd. 5. **Operation of automated drug distribution systems.** (a) The managing pharmacy and the pharmacist in charge are responsible for the operation of an automated drug distribution system.

(b) Access to an automated drug distribution system must be limited to pharmacy and nonpharmacy personnel authorized to procure drugs from the system, except that field service technicians may access a system located in a health care facility for the purposes of servicing and maintaining it while being monitored either by the managing pharmacy, or a licensed nurse within the health care facility. In the case of an automated drug distribution system that is not physically located within a licensed pharmacy, access for the purpose of procuring drugs shall be limited to licensed nurses. Each person authorized to access the system must be assigned an individual specific access code. Alternatively, access to the system may be controlled through the use of biometric identification procedures. A policy specifying time access parameters, including time-outs, logoffs, and lockouts, must be in place.

(c) For the purposes of this section only, the requirements of section 151.215 are met if the following clauses are met:

(1) a pharmacist employed by and working at the managing pharmacy, or at a pharmacy that is acting as a central services pharmacy for the managing pharmacy, pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all prescription drug orders before any drug is distributed from the system to be administered to a patient. A pharmacy technician may perform data entry of prescription drug orders provided that a pharmacist certifies the accuracy of the data entry before the drug can be released from the automated drug distribution system. A pharmacist employed by and working at the managing pharmacy must certify the accuracy of the filling of any cassettes, canisters, or other containers that contain drugs that will be loaded into the automated drug distribution system; and

(2) when the automated drug dispensing system is located and used within the managing pharmacy, a pharmacist must personally supervise and take responsibility for all packaging and labeling associated with the use of an automated drug distribution system.

(d) Access to drugs when a pharmacist has not reviewed and approved the prescription drug order is permitted only when a formal and written decision to allow such access is issued by the pharmacy and the therapeutics committee or its equivalent. The committee must specify the patient care circumstances in which such access is allowed, the drugs that can be accessed, and the staff that are allowed to access the drugs.

(e) In the case of an automated drug distribution system that does not utilize bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician, so long as the activity is continuously supervised, through a two-way audiovisual system by a pharmacist on duty within the managing pharmacy. In the case of an automated drug distribution system that utilizes bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician or a licensed nurse, provided that the managing pharmacy retains an electronic record of loading activities.

(f) The automated drug distribution system must be under the supervision of a pharmacist. The pharmacist is not required to be physically present at the site of the automated drug distribution system if the system is continuously monitored electronically by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the board must be continuously available to address any problems detected by the monitoring or to answer questions from the staff of the health care facility. The licensed pharmacy may be the managing pharmacy or a pharmacy which is acting as a central services pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

Sec. 20. Minnesota Statutes 2013 Supplement, section 152.02, subdivision 2, is amended to read:

Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

(1) acetylmethadol;

(2) allylprodine;

(3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);

(4) alphameprodine;

(5) alphamethadol;

(6) alpha-methylfentanyl benzethidine;

(7) betacetylmethadol;

(8) betameprodine;

(9) betamethadol;

(10) betaprodine;

(11) clonitazene;

(12) dextromoramide;

(13) diampromide;

(14) diethyliambutene;

(15) difenoxin;

(16) dimenoxadol;

(17) dimepheptanol;

(18) dimethyliambutene;

(19) dioxaphetyl butyrate;

(20) dipipanone;

(21) ethylmethylthiambutene;

(22) etonitazene;

(23) etoxeridine;

(24) furethidine;

(25) hydroxypethidine;

(26) ketobemidone;

(27) levomoramide;

(28) levophenacylmorphan;

(29) 3-methylfentanyl;

(30) acetyl-alpha-methylfentanyl;

(31) alpha-methylthiofentanyl;

(32) benzylfentanyl beta-hydroxyfentanyl;

(33) beta-hydroxy-3-methylfentanyl;

(34) 3-methylthiofentanyl;

(35) thenylfentanyl;

(36) thiofentanyl;

(37) para-fluorofentanyl;

(38) morpheridine;

(39) 1-methyl-4-phenyl-4-propionoxypiperidine;

(40) noracymethadol;

(41) norlevorphanol;

(42) normethadone;

(43) norpipanone;

(44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

(45) phenadoxone;

(46) phenampromide;

(47) phenomorphan;

(48) phenoperidine;

(49) piritramide;

(50) proheptazine;

(51) properidine;

(52) propiram;

(53) racemoramide;

(54) tilidine;

(55) trimeperidine.

(56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl).

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine;

(23) thebacon.

(d) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional, or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) methylenedioxy amphetamine;

(2) methylenedioxymethamphetamine;

(3) methylenedioxy-N-ethylamphetamine (MDEA);

(4) n-hydroxy-methylenedioxyamphetamine;

(5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

(6) 2,5-dimethoxyamphetamine (2,5-DMA);

(7) 4-methoxyamphetamine;

(8) 5-methoxy-3, 4-methylenedioxy amphetamine;

(9) alpha-ethyltryptamine;

(10) bufotenine;

(11) diethyltryptamine;

(12) dimethyltryptamine;

(13) 3,4,5-trimethoxy amphetamine;

(14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

(15) ibogaine;

(16) lysergic acid diethylamide (LSD);

(17) mescaline;

(18) parahexyl;

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) psilocybin;

(22) psilocyn;

(23) tenocyclidine (TPCP or TCP);

(24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

(25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

(26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

(27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

(28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

(29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

(30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

(31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

(32) 4-methyl-2,5-dimethoxyphenethylamine (2-CD);

(33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

(34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

(35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

(36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

(37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

(38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);

(39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

(40) alpha-methyltryptamine (AMT);

(41) N,N-diisopropyltryptamine (DiPT);

(42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

(43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

(44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

(45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

(46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

(47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

(48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

(49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

(50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

(51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

(52) 5-methoxy-N-methyl-N-propyltryptamine (5-MeO-MiPT);

(53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

(54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

(55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

(56) 5-methoxy-N,N-diallytryptamine (5-MeO-DALT);

(57) methoxetamine (MXE);

(58) 5-iodo-2-aminoindane (5-IAI);

(59) 5,6-methylenedioxy-2-aminoindane (MDAI);

(60) 2-(4-iodo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (25I-NBOMe).

(e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) mecloqualone;

(2) methaqualone;

(3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

(4) flunitrazepam.

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) aminorex;

(2) cathinone;

(3) fenethylline;

(4) methcathinone;

(5) methylaminorex;

(6) N,N-dimethylamphetamine;

(7) N-benzylpiperazine (BZP);

(8) methylmethcathinone (mephedrone);

(9) 3,4-methylenedioxy-N-methylcathinone (methylone);

(10) methoxymethcathinone (methedrone);

(11) methylenedioxypyrovalerone (MDPV);

(12) fluoromethcathinone;

(13) methylethcathinone (MEC);

(14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

(15) dimethylmethcathinone (DMMC);

(16) fluoroamphetamine;

(17) fluoromethamphetamine;

(18) α-methylaminobutyrophenone (MABP or buphedrone);

(19) β-keto-N-methylbenzodioxolylpropylamine (bk-MBDB or butylone);

(20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

(21) naphthylpyrovalerone (naphyrone); ~~and~~

(22) (RS)-1-phenyl-2-(1-pyrrolidinyl)-1-pentanone (alpha-PVP or alpha-pyrrolidinovalerophenone);

(23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP); and

~~(22)~~ (24) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) Marijuana, tetrahydrocannabinols, and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any natural or synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(1) marijuana;

(2) tetrahydrocannabinols naturally contained in a plant of the genus Cannabis, synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

(3) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butul-3-(1-naphthoyl)indole (JWH-073);

(C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

(D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

(F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

(G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

(I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Napthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

(A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

(B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methan (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an allkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylemethylindenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

(A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

(B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

(D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl] -phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de] -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22).~~,~~ ;

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamide (AB-FUBINACA).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly intended for human consumption.

# ARTICLE 6

# HEALTH DEPARTMENT AND PUBLIC HEALTH

Section 1. Minnesota Statutes 2012, section 62J.497, subdivision 5, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, ~~2015~~ 2017, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

Sec. 2. Minnesota Statutes 2012, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out its responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process

consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 3. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:

Subd. 10. **Suspension.** Notwithstanding subdivisions 3, 3a, 3b, 3c, and 3d, the commissioner shall suspend the development and implementation of the provider peer grouping system required under this section. This suspension shall continue until the legislature authorizes the commissioner to resume this activity.

Sec. 4. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations; and

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2016.

Sec. 5. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:

Subd. 12. **All-payer claims database work group.** (a) The commissioner of health shall convene a work group to develop a framework for the expanded use of the all-payer claims database established under this section. The work group shall develop recommendations based on the following questions and other topics as identified by the work group:

(1) what should the parameters be for allowable uses of the all-payer claims data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11;

(2) what type of advisory or governing body should guide the release of data from the all-payer claims database;

(3) what type of funding or fee structure would be needed to support the expanded use of all-payer claims data;

(4) what should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access;

(5) what are the appropriate privacy and security protections needed for the expanded use of the all-payer claims database; and

(6) what additional resources might be needed to support the expanded use of the all-payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts.

(b) The commissioner of health shall appoint the members to the work group as follows:

(1) two members recommended by the Minnesota Medical Association;

(2) two members recommended by the Minnesota Hospital Association;

(3) two members recommended by the Minnesota Council of Health Plans;

(4) one member who is a data practices expert from the Department of Administration;

(5) three members who are academic researchers with expertise in claims database analysis;

(6) two members representing two state agencies determined by the commissioner;

(7) one member representing the Minnesota Health Care Safety Net Coalition; and

(8) three members representing consumers.

(c) The commissioner of health shall submit a report on the recommendations of the work group to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services, judiciary, and civil law by February 1, 2015. In considering the recommendations provided in the report, the legislature may consider whether the currently authorized uses of the all-payer claims data under this section should continue to be authorized.

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

Sec. 6. Minnesota Statutes 2013 Supplement, section 144.1225, subdivision 2, is amended to read:

Subd. 2. **Accreditation required.** (a)(1) Except as otherwise provided in ~~paragraph~~ paragraphs (b) and (c), advanced diagnostic imaging services eligible for reimbursement from any source, including, but not limited to, the individual receiving such services and any individual or group insurance contract, plan, or policy delivered in this state, including, but not limited to, private health insurance plans, workers' compensation insurance, motor vehicle insurance, the State Employee Group Insurance Program (SEGIP), and other state health care programs, shall be reimbursed only if the facility at which the service has been conducted and processed is licensed pursuant to sections 144.50 to 144.56 or accredited by one of the following entities:

(i) American College of Radiology (ACR);

(ii) Intersocietal Accreditation Commission (IAC);

(iii) the Joint Commission; or

(iv) other relevant accreditation organization designated by the Secretary of the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1395M.

(2) All accreditation standards recognized under this section must include, but are not limited to:

(i) provisions establishing qualifications of the physician;

(ii) standards for quality control and routine performance monitoring by a medical physicist;

(iii) qualifications of the technologist, including minimum standards of supervised clinical experience;

(iv) guidelines for personnel and patient safety; and

(v) standards for initial and ongoing quality control using clinical image review and quantitative testing.

(b) Any facility that performs advanced diagnostic imaging services and is eligible to receive reimbursement for such services from any source in paragraph (a), clause (1), must obtain licensure pursuant to sections 144.50 to 144.56 or accreditation pursuant to paragraph (a) by August 1, 2013. Thereafter, all facilities that provide advanced diagnostic imaging services in the state must obtain licensure or accreditation prior to commencing operations and must, at all times, maintain either licensure pursuant to sections 144.50 to 144.56 or accreditation with an accrediting organization as provided in paragraph (a).

(c) Dental clinics or offices that perform diagnostic imaging through dental cone beam computerized tomography do not need to meet the accreditation or reporting requirements in this section.

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

Sec. 7. Minnesota Statutes 2012, section 144.125, subdivision 3, is amended to read:

Subd. 3. **Information provided to parents and legal guardians.** (a) The department shall make information and forms available to childbirth education programs and health care providers who provide prenatal care describing the newborn screening program and the provisions of this section to be used in a discussion with expectant parents and parents of newborns. The department shall make information and forms about newborn screening available to the persons with a duty to perform testing under this section and to expectant parents and parents of newborns using electronic and other means.

(b) Prior to collecting a sample, persons with a duty to perform testing under subdivision 1 must:

(1) provide parents or legal guardians of infants with a document that provides the following information:

(i) the benefits of newborn screening;

(ii) that the blood sample will be used to test for heritable and congenital disorders, as determined under subdivision 2;

(iii) the data that will be collected as part of the testing;

(iv) ~~the standard retention periods for blood samples and test results as provided in subdivision 6~~ the benefits associated with the department's storage of an infant's blood sample and test results;

(v) that the Department of Health may store the blood samples and test results unless the parent or legal guardian elects to not have them stored;

~~(v)~~ (vi) that blood samples and test results will be used for program operations ~~during the standard retention period~~ in accordance with subdivision 5, unless the parents or legal guardians elect not to have the blood samples and test results stored;

~~(vi)~~ (vii) the Department of Health's Web site address where more information and forms may be obtained; ~~and~~

~~(vii)~~ (viii) that parents or legal guardians have a right to elect not to have newborn screening performed and a right to secure private testing;

(ix) that parents or legal guardians have a right to elect to have the newborn screening performed, but not have the blood samples and test results stored; and

(x) that parents or legal guardians have a right to authorize in writing that the blood samples and test results may be used for public health studies or research; and

(2) upon request, provide parents or legal guardians of infants with forms necessary to request that the infant not have blood collected for testing or to request to have the newborn screening performed, but not have the blood samples and test results stored; and

(3) record in the infant's medical record that a parent or legal guardian of the infant has received the information provided pursuant to this subdivision and has had an opportunity to ask questions.

(c) Nothing in this section prohibits a parent or legal guardian of an infant from having newborn screening performed by a private entity.

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

Sec. 8. Minnesota Statutes 2012, section 144.125, subdivision 4, is amended to read:

Subd. 4. **Parental options.** (a) The parent or legal guardian of an infant otherwise subject to testing under this section may elect not to have newborn screening performed, or may elect to have newborn screening tests performed, but not to have the blood samples and test results stored.

(b) If a parent or legal guardian elects not to have newborn screening performed or elects not to allow the blood samples and test results to be stored, then the election ~~shall~~ must be recorded on a form that is signed by the parent or legal guardian. The signed form ~~shall~~ must be made part of the infant's medical record and a copy shall be provided to the Department of Health. When a parent or legal guardian elects not to have newborn screening performed, the person with the duty to perform testing under subdivision 1 must follow that election. A written election to decline testing exempts persons with a duty to perform testing and the Department of Health from the requirements of this section and section 144.128.

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

Sec. 9. Minnesota Statutes 2012, section 144.125, subdivision 5, is amended to read:

Subd. 5. **Newborn screening program operations.** (a) "Newborn screening program operations" means actions, testing, and procedures directly related to the operation of the newborn screening program, limited to the following:

(1) confirmatory testing;

(2) laboratory quality control assurance and improvement;

(3) calibration of equipment;

(4) evaluating and improving the accuracy of newborn screening tests for conditions approved for screening in Minnesota;

(5) validation of equipment and screening methods; ~~and~~

(6) continuity of operations to ensure testing can continue as required by Minnesota law in the event of an emergency; and

(7) utilization of blood samples and test results for studies related to newborn screening, including studies used to develop new tests.

(b) No research, or public health studies~~, or development of new newborn screening tests shall be conducted under this subdivision~~ other than those described in paragraph (a) shall be conducted without written consent as described under subdivision 7.

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

Sec. 10. Minnesota Statutes 2013 Supplement, section 144.125, subdivision 7, is amended to read:

Subd. 7. **Parental options for ~~extended storage and use~~ additional research.** (a) The parent or legal guardian of an infant ~~otherwise~~ subject to testing under this section may authorize in writing that the infant's blood sample and test results be retained and used by the Department of Health ~~beyond the standard retention periods provided in subdivision 6~~ for the purposes described in subdivision 9.

(b) The Department of Health must provide a consent form, with an attached Tennessen warning pursuant to section 13.04, subdivision 2. The consent form must provide the following:

~~(1) information as to the personal identification and use of samples and test results for studies, including studies used to develop new tests;~~

~~(2)~~ (1) information as to the personal identification and use of samples and test results for public health studies or research not related to newborn screening;

~~(3) information that explains that the Department of Health will not store a blood sample or test result for longer than 18 years from an infant's birth date;~~

~~(4)~~ (2) information that explains that, upon approval by the Department of Health's Institutional Review Board, blood samples and test results may be shared with external parties for public health studies or research; and

~~(5)~~ (3) information that explains that blood samples contain various components, including deoxyribonucleic acid (DNA)~~; and~~

~~(6) the benefits and risks associated with the department's storage of a child's blood sample and test results~~.

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

Sec. 11. Minnesota Statutes 2012, section 144.125, subdivision 8, is amended to read:

Subd. 8. **~~Extended~~ Storage and use of samples and test results.** ~~When authorized in writing by a parent or legal guardian under subdivision 7,~~ (a) The Department of Health may store blood samples and test results ~~for a time period not to exceed 18 years from the infant's birth date~~, and may use the blood samples and test results in accordance with subdivision ~~9~~ 5, unless a parent or legal guardian elects against the storage of the blood samples and test results, and in accordance with subdivision 9, if written informed consent of a parent or legal guardian is obtained.

(b) If a parent, legal guardian, or individual elects against storage or revokes prior consent for storage, the blood samples must be destroyed within one week of receipt of

the request, and test results must be destroyed at the earliest time allowed under Clinical Laboratory Improvement Amendments (CLIA) regulations.

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

Sec. 12. Minnesota Statutes 2012, section 144.125, subdivision 9, is amended to read:

Subd. 9. **Written, informed consent for other use of samples and test results.** With the written, informed consent of a parent or legal guardian, the Department of Health may~~:~~

~~(1) use blood samples and test results for studies related to newborn screening, including studies used to develop new tests; and~~

~~(2)~~ use blood samples and test results for public health studies or research not related to newborn screening, and upon approval by the Department of Health's Institutional Review Board, share samples and test results with external parties for public health studies or research.

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

Sec. 13. Minnesota Statutes 2012, section 144.125, subdivision 10, is amended to read:

Subd. 10. **Revoking consent for storage and use.** A parent or legal guardian, or the individual whose blood was tested as an infant if the individual is 18 years of age or older, may revoke approval for ~~extended~~ storage or use of blood samples or test results at any time by providing a signed and dated form requesting destruction of the blood samples or test results. The Department of Health shall make necessary forms available on the department's Web site. Blood samples must be destroyed within one week of receipt of a request ~~or within one week of the standard retention period for blood samples provided in subdivision 6, whichever is later.~~ and test results must be destroyed ~~within one month of receipt of a request or within one month of the standard retention period for test results provided in subdivision 6, whichever is later~~ at the earliest time allowed under Clinical Laboratory Improvement Amendments (CLIA) regulations.

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

Sec. 14. Minnesota Statutes 2012, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Dentist" means an individual who is licensed to practice dentistry.

(c) "Designated rural area" means ~~an area defined as a small rural area or isolated rural area according to the four category classifications of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration~~ a city or township that is:

(1) outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2; and

(2) has a population under 15,000.

(d) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(e) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(f) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(g) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(h) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(i) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(j) "Pharmacist" means an individual with a valid license issued under chapter 151.

(k) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(l) "Physician assistant" means a person licensed under chapter 147A.

(m) "Qualified educational loan" means a government, commercial, or foundation loan 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.

(n) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 15. Minnesota Statutes 2012, section 144.4165, is amended to read:

**144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.**

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product, or inhale or exhale vapor from an electronic delivery device, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755 subdivision 12.

Sec. 16. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a comprehensive stroke center if the hospital has been certified as a comprehensive stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Sec. 17. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 2, is amended to read:

Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke center if the hospital has been certified as a primary stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Sec. 18. Minnesota Statutes 2012, section 144.565, subdivision 4, is amended to read:

Subd. 4. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Diagnostic imaging facility" means a health care facility that is not a hospital or location licensed as a hospital which offers diagnostic imaging services in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center. A dental clinic or office is not considered a diagnostic imaging facility for the purpose of this section when the clinic or office performs diagnostic imaging through dental cone beam computerized tomography.

(b) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging

(MRI) or computerized tomography (CT) other than dental cone beam computerized tomography, positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

(c) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

(d) "Fixed equipment" means a stationary diagnostic imaging machine installed in a permanent location.

(e) "Mobile equipment" means a diagnostic imaging machine in a self-contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(f) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(g) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

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

Sec. 19. **[144.6586] NOTICE OF RIGHTS TO SEXUAL ASSAULT VICTIM.**

Subdivision 1. **Notice required.** A hospital shall give a written notice about victim rights and available resources to a person seeking medical services in the hospital who reports to hospital staff or who evidences a sexual assault or other unwanted sexual contact or sexual penetration. The hospital shall make a good faith effort to provide this notice prior to medical treatment or the examination performed for the purpose of gathering evidence, subject to applicable federal and state laws and regulations regarding the provision of medical care, and in a manner that does not interfere with any

medical screening examination or initiation of treatment necessary to stabilize a victim's emergency medical condition.

Subd. 2. **Contents of notice.** The commissioners of health and public safety, in consultation with sexual assault victim advocates and health care professionals, shall develop the notice required by subdivision 1. The notice must inform the victim, at a minimum, of:

(1) the obligation under section 609.35 of the county where the criminal sexual conduct occurred to pay for the examination performed for the purpose of gathering evidence, that payment is not contingent on the victim reporting the criminal sexual conduct to law enforcement, and that the victim may incur expenses for treatment of injuries; and

(2) the victim's rights if the crime is reported to law enforcement, including the victim's right to apply for reparations under sections 611A.51 to 611A.68, information on how to apply for reparations, and information on how to obtain an order for protection or a harassment restraining order.

Sec. 20. Minnesota Statutes 2013 Supplement, section 144A.474, subdivision 12, is amended to read:

Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care providers a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in subdivision 11, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department shall post information on the Web site with the correction order that the licensee has requested a reconsideration and that the review is pending.

(b) A licensed home care provider may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the provider. The written request for reconsideration must be received by the commissioner within 15 calendar days of the correction order issuance date. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in the writing or reviewing of the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a home care provider for a correction order reconsideration within 60 days of the date the provider requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the home care provider.

(c) The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full, the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance, the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect home care licensing requirement, the correction order is amended by changing the correction order to the appropriate statutory reference;

(4) correction order was issued under an incorrect citation, the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended, it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

(d) If the correction order findings are changed by the commissioner, the commissioner shall update the correction order Web site.

(e) This subdivision does not apply to temporary licensees.

**EFFECTIVE DATE.** This section is effective August 1, 2014, and for current licensees as of December 31, 2013, on or after July 1, 2014, upon license renewal.

Sec. 21. Minnesota Statutes 2013 Supplement, section 144A.475, subdivision 3, is amended to read:

Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 90 days if the commissioner determines that ~~the health or safety of a consumer is in imminent danger,~~ there are level 3 or 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), provided:

(1) advance notice is given to the home care provider;

(2) after notice, the home care provider fails to correct the problem;

(3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and

(4) there is an opportunity for a contested case hearing within the ~~90~~ 30 days unless there is an extension granted by an administrative law judge pursuant to subdivision 3b.

**EFFECTIVE DATE.** The amendments to this section are effective August 1, 2014, and for current licensees as of December 31, 2013, on or after July 1, 2014, upon license renewal.

Sec. 22. Minnesota Statutes 2013 Supplement, section 144A.475, is amended by adding a subdivision to read:

Subd. 3a. **Hearing.** Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee. If, while a licensee continues to operate pending an appeal of an order for revocation, suspension, or refusal to renew a license, the commissioner identifies one or more new violations of law that meet the requirements of level 3 or 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), the commissioner shall act immediately to temporarily suspend the license under the provisions in subdivision 3.

**EFFECTIVE DATE.** This section is effective for appeals received on or after August 1, 2014.

Sec. 23. Minnesota Statutes 2013 Supplement, section 144A.475, is amended by adding a subdivision to read:

Subd. 3b. **Temporary suspension expedited hearing.** (a) Within five business days of receipt of the license holder's timely appeal of a temporary suspension, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension should remain in effect and whether there is sufficient

evidence to conclude that the licensee's actions or failure to comply with applicable laws are level 3 or 4 violations as defined in section 144A.474, subdivision 11, paragraph (b).

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten business days from the close of the record. When an appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. The license holder is prohibited from operation during the 90-day temporary suspension period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that sanction, the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14.

**EFFECTIVE DATE.** This section is effective August 1, 2014.

Sec. 24. Minnesota Statutes 2012, section 144D.065, is amended to read:

**144D.065 TRAINING IN DEMENTIA CARE REQUIRED.**

(a) If a housing with services establishment registered under this chapter has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the establishment as providing services for persons with Alzheimer's disease or ~~related disorders~~ other dementias, whether in a segregated or general unit, ~~the establishment's direct care staff and their supervisors must be trained in dementia care.~~ employees of the establishment and of the establishment's arranged home care provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A

trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

(d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements:

(1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial four hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or supervisor meeting the requirements under paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.

**EFFECTIVE DATE.** This section is effective January 1, 2016.

Sec. 25. **[144D.10] MANAGER REQUIREMENTS.**

(a) The person primarily responsible for oversight and management of a housing with services establishment, as designated by the owner of the housing with services establishment, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the housing with services establishment and the needs of its tenants. Continuing education earned to maintain a professional license, such as nursing home administrator license, nursing license, social worker license, and real estate license, can be used to complete this requirement.

(b) For managers of establishments identified in section 325F.72, this continuing education must include at least eight hours of documented training on the topics identified in section 144D.065, subdivision 1, paragraph (b), within 160 working hours of hire, and two hours of training these topics for each 12 months of employment thereafter.

(c) For managers of establishments not covered by section 325F.72, but who provide assisted living services under chapter 144G, this continuing education must include at least four hours of documented training on the topics identified in section 144D.065, subdivision 1, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(d) A statement verifying compliance with the continuing education requirement must be included in the housing with services establishment's annual registration to the commissioner of health. The establishment must maintain records for at least three years demonstrating that the person primarily responsible for oversight and management of the establishment has attended educational programs as required by this section.

(e) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

(f) This section does not apply to an establishment registered under section 144D.025 serving the homeless.

**EFFECTIVE DATE.** This section is effective January 1, 2016.

Sec. 26. **[144D.11] EMERGENCY PLANNING.**

(a) Each registered housing with services establishment must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all tenants upon signing a lease;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing tenants.

(b) Each registered housing with services establishment must provide emergency and disaster training to all staff within 30 days of hire and annually thereafter and must make emergency and disaster training available to all tenants annually.

(c) Each registered housing with services location must conduct and document a fire drill or other emergency drill at least every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

**EFFECTIVE DATE.** This section is effective January 1, 2016.

Sec. 27. Minnesota Statutes 2013 Supplement, section 145.4716, subdivision 2, is amended to read:

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718;

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

~~(6)~~ (7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

~~(7)~~ (8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

~~(8)~~ (9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 28. Minnesota Statutes 2012, section 145.928, is amended by adding a subdivision to read:

Subd. 7a. **Minority run health care professional associations.** The commissioner shall award grants to minority run health care professional associations to achieve the following:

(1) provide collaborative mental health services to minority residents;

(2) provide collaborative, holistic, and culturally competent health care services in communities with high concentrations of minority residents; and

(3) collaborate on recruitment, training, and placement of minorities with health care providers.

Sec. 29. Minnesota Statutes 2012, section 149A.92, is amended by adding a subdivision to read:

Subd. 11. **Scope.** Notwithstanding the requirements in section 149A.50, this section applies only to funeral establishments where human remains are present for the purpose of preparation and embalming, private viewings, visitations, services, and holding of human remains while awaiting final disposition. For the purpose of this subdivision, "private viewing" means viewing of a dead human body by persons designated in section 149A.80, subdivision 2.

Sec. 30. Minnesota Statutes 2012, section 325H.05, is amended to read:

**325H.05 POSTED WARNING REQUIRED.**

(a) The facility owner or operator shall conspicuously post the warning ~~sign~~ signs described in ~~paragraph~~ paragraphs (b) and (c) within three feet of each tanning station. The sign must be clearly visible, not obstructed by any barrier, equipment, or other object,

and must be posted so that it can be easily viewed by the consumer before energizing the tanning equipment.

(b) The warning sign required in paragraph (a) shall have dimensions not less than eight inches by ten inches, and must have the following wording:

"DANGER - ULTRAVIOLET RADIATION

-Follow instructions.

-Avoid overexposure. As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. Repeated exposure may cause premature aging of the skin and skin cancer.

-Wear protective eyewear.

FAILURE TO USE PROTECTIVE EYEWEAR MAY RESULT IN SEVERE BURNS OR LONG-TERM INJURY TO THE EYES.

-Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult a physician before using sunlamp or tanning equipment if you are using medications or have a history of skin problems or believe yourself to be especially sensitive to sunlight."

(c) All tanning facilities must prominently display a sign in a conspicuous place, at the point of sale, that states it is unlawful for a tanning facility or operator to allow a person under age 18 to use any tanning equipment.

Sec. 31. **[325H.085] USE BY MINORS PROHIBITED.**

A person under age 18 may not use any type of tanning equipment as defined by section 325H.01, subdivision 6, available in a tanning facility in this state.

Sec. 32. Minnesota Statutes 2012, section 325H.09, is amended to read:

**325H.09 PENALTY.**

Any person who leases tanning equipment or who owns a tanning facility and who operates or permits the equipment or facility to be operated in noncompliance with the requirements of sections 325H.01 to ~~325H.08~~ 325H.085 is guilty of a petty misdemeanor.

Sec. 33. **[403.51] AUTOMATIC EXTERNAL DEFIBRILLATION; REGISTRATION.**

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

(b) "Automatic external defibrillator" or "AED" means an electronic device designed and manufactured to operate automatically or semiautomatically for the purpose of delivering an electrical current to the heart of a person in sudden cardiac arrest.

(c) "AED registry" means a registry of AEDs that requires a maintenance program or package, and includes, but is not limited to, the following registries: the Minnesota AED Registry, the National AED Registry, iRescU, or a manufacturer-specific program.

(d) "Person" means a natural person, partnership, association, corporation, or unit of government.

(e) "Public access AED" means any AED that is intended, by its markings or display, to be used or accessed by the public for the benefit of the general public that may happen to be in the vicinity or location of that AED. It does not include an AED that is owned or used by a hospital, clinic, business, or organization that is intended to be used by staff and is not marked or displayed in a manner to encourage public access.

(f) "Maintenance program or package" means a program that will alert the AED owner when the AED has electrodes and batteries due to expire or replaces those expiring electrodes and batteries for the AED owner.

(g) "Public safety agency" means local law enforcement, county sheriff, municipal police, tribal agencies, state law enforcement, fire departments, including municipal departments, industrial fire brigades, and nonprofit fire departments, joint powers agencies, and licensed ambulance services.

(h) "Mobile AED" means an AED that (1) is purchased with the intent of being located in a vehicle, including, but not limited to, public safety agency vehicles; or (2) will not be placed in stationary storage, including, but not limited to, an AED used at an athletic event.

(i) "Private use AED" means an AED that is not intended to be used or accessed by the public for the benefit of the general public. This may include, but is not limited to, AEDs found in private residences.

Subd. 2. **Registration.** A person who purchases or obtains a public access AED shall register that device with an AED registry within 30 working days of receiving the AED.

Subd. 3. **Required information.** A person registering a public access AED shall provide the following information for each AED:

(1) AED manufacturer, model, and serial number;

(2) specific location where the AED will be kept; and

(3) the title, address, and telephone number of a person in management at the business or organization where the AED is located.

Subd. 4. **Information changes.** The owner of a public access AED shall notify their AED registry of any changes in the information that is required in the registration within 30 working days of the change occurring.

Subd. 5. **Public access AED requirements.** A public access AED:

(1) may be inspected during regular business hours by a public safety agency with jurisdiction over the location of the AED;

(2) shall be kept in the location specified in the registration; and

(3) shall be reasonably maintained, including replacement of dead batteries and pads/electrodes, and comply with all manufacturer's recall and safety notices.

Subd. 6. **Removal of AED.** An authorized agent of a public safety agency with jurisdiction over the location of the AED may direct the owner of a public access AED to comply with this section. Such authorized agent of a public safety agency may direct the owner of the AED to remove the AED from its public access location and to remove or cover any public signs relating to that AED if it is determined that the AED is not ready for immediate use.

Subd. 7. **Private use AEDs.** The owner of a private use AED is not subject to the requirements of this section but is encouraged to maintain the AED in a consistent manner.

Subd. 8. **Mobile AEDs.** The owner of a mobile AED is not subject to the requirements of this section but is encouraged to maintain the AED in a consistent manner.

Subd. 9. **Signs.** A person acquiring a public use AED is encouraged but is not required to post signs bearing the universal AED symbol in order to increase the ease of access by the public to the AED in the event of an emergency. A person may not post any AED sign or allow any AED sign to remain posted upon being ordered to remove or cover any AED signs by an authorized agent of a public safety agency.

Subd. 10. **Emergency response plans.** The owner of one or more public access AEDs shall develop an emergency response plan appropriate for the nature of the facility the AED is intended to serve.

Subd. 11. **No civil liability.** Nothing in this section shall create any civil liability on the part of an AED owner.

**EFFECTIVE DATE.** This section is effective August 1, 2014.

Sec. 34. Minnesota Statutes 2012, section 461.12, is amended to read:

**461.12 MUNICIPAL ~~TOBACCO~~ LICENSE OF TOBACCO, TOBACCO-RELATED DEVICES, AND SIMILAR PRODUCTS.**

Subdivision 1. **Authorization.** A town board or the governing body of a home rule charter or statutory city may license and regulate the retail sale of tobacco ~~and~~, tobacco-related devices, and electronic delivery devices as defined in section 609.685, subdivision 1, and nicotine and lobelia delivery products as described in section 609.6855, and establish a license fee for sales to recover the estimated cost of enforcing this chapter. The county board shall license and regulate the sale of tobacco ~~and~~, tobacco-related devices, electronic delivery devices, and nicotine and lobelia products in unorganized territory of the county except on the State Fairgrounds and in a town or a home rule charter or statutory city if the town or city does not license and regulate retail sales of tobacco ~~sales~~, tobacco-related devices, electronic delivery devices, and nicotine and lobelia delivery products. The State Agricultural Society shall license and regulate the sale of tobacco, tobacco-related devices, electronic delivery devices, and nicotine and lobelia delivery products on the State Fairgrounds. Retail establishments licensed by a town or city to sell tobacco, tobacco-related devices, electronic delivery devices, and nicotine and lobelia delivery products are not required to obtain a second license for the same location under the licensing ordinance of the county.

Subd. 2. **Administrative penalties; licensees.** If a licensee or employee of a licensee sells tobacco ~~or~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of 18 years, or violates any other provision of this chapter, the licensee shall be charged an administrative penalty of $75. An administrative penalty of $200 must be imposed for a second violation at the same location within 24 months after the initial violation. For a third violation at the same location within 24 months after the initial violation, an administrative penalty of $250 must be imposed, and the licensee's authority to sell tobacco, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products at that location must be suspended for not less than seven days. No suspension or penalty may take effect until the licensee has received notice, served personally or by mail, of the alleged violation and an opportunity for a hearing before a person authorized by the licensing authority to conduct the hearing. A decision that a violation has occurred must be in writing.

Subd. 3. **Administrative penalty; individuals.** An individual who sells tobacco ~~or~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of 18 years must be charged an administrative penalty of $50. No penalty may be imposed until the individual has received notice, served personally or by mail, of the alleged violation and an opportunity for a hearing before a person authorized by the licensing authority to conduct the hearing. A decision that a violation has occurred must be in writing.

Subd. 4. **Minors.** The licensing authority shall consult with interested educators, parents, children, and representatives of the court system to develop alternative penalties for minors who purchase, possess, and consume tobacco ~~or~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products. The licensing authority and the interested persons shall consider a variety of options, including, but not limited to, tobacco free education programs, notice to schools, parents, community service, and other court diversion programs.

Subd. 5. **Compliance checks.** A licensing authority shall conduct unannounced compliance checks at least once each calendar year at each location where tobacco ~~is~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products are sold to test compliance with ~~section~~ sections 609.685 and 609.6855. Compliance checks must involve minors over the age of 15, but under the age of 18, who, with the prior written consent of a parent or guardian, attempt to purchase tobacco ~~or~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products under the direct supervision of a law enforcement officer or an employee of the licensing authority.

Subd. 6. **Defense.** It is an affirmative defense to the charge of selling tobacco ~~or~~, tobacco-related devices, electronic delivery devices, or nicotine or lobelia delivery products to a person under the age of 18 years in violation of subdivision 2 or 3 that the licensee or individual making the sale relied in good faith upon proof of age as described in section 340A.503, subdivision 6.

Subd. 7. **Judicial review.** Any person aggrieved by a decision under subdivision 2 or 3 may have the decision reviewed in the district court in the same manner and procedure as provided in section 462.361.

Subd. 8. **Notice to commissioner.** The licensing authority under this section shall, within 30 days of the issuance of a license, inform the commissioner of revenue of the licensee's name, address, trade name, and the effective and expiration dates of the license. The commissioner of revenue must also be informed of a license renewal, transfer, cancellation, suspension, or revocation during the license period.

Sec. 35. Minnesota Statutes 2012, section 461.18, is amended to read:

**461.18 BAN ON SELF-SERVICE SALE OF PACKS; EXCEPTIONS.**

Subdivision 1. **Except in adult-only facilities.** (a) No person shall offer for sale tobacco or tobacco-related devices, or electronic delivery devices as defined in section 609.685, subdivision 1, or nicotine or lobelia delivery products as described in section 609.6855, in open displays which are accessible to the public without the intervention of a store employee.

(b) [Expired August 28, 1997]

(c) [Expired]

(d) This subdivision shall not apply to retail stores which derive at least 90 percent of their revenue from tobacco and tobacco-related ~~products~~ devices and where the retailer ensures that no person younger than 18 years of age is present, or permitted to enter, at any time.

Subd. 2. **Vending machine sales prohibited.** No person shall sell tobacco products, electronic delivery devices, or nicotine or lobelia delivery products from vending machines. This subdivision does not apply to vending machines in facilities that cannot be entered at any time by persons younger than 18 years of age.

Subd. 3. **Federal regulations for cartons, multipacks.** Code of Federal Regulations, title 21, part 897.16(c), is incorporated by reference with respect to cartons and other multipack units.

Sec. 36. Minnesota Statutes 2012, section 461.19, is amended to read:

**461.19 EFFECT ON LOCAL ORDINANCE; NOTICE.**

Sections 461.12 to 461.18 do not preempt a local ordinance that provides for more restrictive regulation of sales of tobacco ~~sales~~, tobacco-related devices, electronic delivery devices, and nicotine and lobelia products. A governing body shall give notice of its intention to consider adoption or substantial amendment of any local ordinance required under section 461.12 or permitted under this section. The governing body shall take reasonable steps to send notice by mail at least 30 days prior to the meeting to the last known address of each licensee or person required to hold a license under section 461.12. The notice shall state the time, place, and date of the meeting and the subject matter of the proposed ordinance.

Sec. 37. Minnesota Statutes 2012, section 609.685, is amended to read:

**609.685 SALE OF TOBACCO TO CHILDREN.**

Subdivision 1. **Definitions.** For the purposes of this section, the following terms shall have the meanings respectively ascribed to them in this section.

(a) "Tobacco" means cigarettes and any product containing, made, or derived from tobacco that is intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, or any component, part, or accessory of a tobacco product~~;~~ including but not limited to cigars; cheroots; stogies; perique; granulated, plug cut, crimp cut, ready rubbed, and other smoking tobacco; snuff; snuff flour; cavendish; plug and twist tobacco; fine cut and other chewing tobaccos;

shorts; refuse scraps, clippings, cuttings and sweepings of tobacco; and other kinds and forms of tobacco. Tobacco excludes any tobacco product that has been approved by the United States Food and Drug Administration for sale as a tobacco-cessation product, as a tobacco-dependence product, or for other medical purposes, and is being marketed and sold solely for such an approved purpose.

(b) "Tobacco-related devices" means cigarette papers or pipes for smoking or other devices intentionally designed or intended to be used in a manner which enables the chewing, sniffing, smoking, or inhalation of vapors of tobacco or tobacco products. Tobacco-related devices include components of tobacco-related devices which may be marketed or sold separately.

(c) "Electronic delivery device" means any product containing or delivering nicotine, lobelia, or any other substance intended for human consumption that can be used by a person to simulate smoking in the delivery of nicotine or any other substance through inhalation of vapor from the product. Electronic delivery device includes any component part of a product, whether or not marketed or sold separately. Electronic delivery device does not include any product that has been approved or certified by the United States Food and Drug Administration for sale as a tobacco-cessation product, as a tobacco-dependence product, or for other medical purposes, and is marketed and sold for such an approved purpose.

Subd. 1a. **Penalty to sell.** (a) Whoever sells tobacco, tobacco-related devices, or electronic delivery devices to a person under the age of 18 years is guilty of a misdemeanor for the first violation. Whoever violates this subdivision a subsequent time within five years of a previous conviction under this subdivision is guilty of a gross misdemeanor.

(b) It is an affirmative defense to a charge under this subdivision if the defendant proves by a preponderance of the evidence that the defendant reasonably and in good faith relied on proof of age as described in section 340A.503, subdivision 6.

Subd. 2. **Other offenses.** (a) Whoever furnishes tobacco ~~or~~, tobacco-related devices, or electronic delivery devices to a person under the age of 18 years is guilty of a misdemeanor for the first violation. Whoever violates this paragraph a subsequent time is guilty of a gross misdemeanor.

(b) A person under the age of 18 years who purchases or attempts to purchase tobacco ~~or~~, tobacco-related devices, or electronic delivery devices and who uses a driver's license, permit, Minnesota identification card, or any type of false identification to misrepresent the person's age, is guilty of a misdemeanor.

Subd. 3. **Petty misdemeanor.** Except as otherwise provided in subdivision 2, whoever possesses, smokes, chews, or otherwise ingests, purchases, or attempts to

purchase tobacco ~~or tobacco related~~, tobacco-related devices, or electronic delivery devices and is under the age of 18 years is guilty of a petty misdemeanor.

Subd. 4. **Effect on local ordinances.** Nothing in subdivisions 1 to 3 shall supersede or preclude the continuation or adoption of any local ordinance which provides for more stringent regulation of the subject matter in subdivisions 1 to 3.

Subd. 5. **Exceptions.** (a) Notwithstanding subdivision 2, an Indian may furnish tobacco to an Indian under the age of 18 years if the tobacco is furnished as part of a traditional Indian spiritual or cultural ceremony. For purposes of this paragraph, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

(b) The penalties in this section do not apply to a person under the age of 18 years who purchases or attempts to purchase tobacco ~~or~~, tobacco-related devices, or electronic delivery devices while under the direct supervision of a responsible adult for training, education, research, or enforcement purposes.

Subd. 6. **Seizure of false identification.** A retailer may seize a form of identification listed in section 340A.503, subdivision 6, if the retailer has reasonable grounds to believe that the form of identification has been altered or falsified or is being used to violate any law. A retailer that seizes a form of identification as authorized under this subdivision shall deliver it to a law enforcement agency within 24 hours of seizing it.

Sec. 38. Minnesota Statutes 2012, section 609.6855, is amended to read:

**609.6855 SALE OF NICOTINE DELIVERY PRODUCTS TO CHILDREN.**

Subdivision 1. **Penalty to sell.** (a) Whoever sells to a person under the age of 18 years a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, is guilty of a misdemeanor for the first violation. Whoever violates this subdivision a subsequent time within five years of a previous conviction under this subdivision is guilty of a gross misdemeanor.

(b) It is an affirmative defense to a charge under this subdivision if the defendant proves by a preponderance of the evidence that the defendant reasonably and in good faith relied on proof of age as described in section 340A.503, subdivision 6.

(c) Notwithstanding paragraph (a), a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, may be sold to persons under the age of 18 if the product has been approved or otherwise certified for legal sale by the United States Food and Drug Administration for tobacco use cessation, harm

reduction, or for other medical purposes, and is being marketed and sold solely for that approved purpose.

Subd. 2. **Other offense.** A person under the age of 18 years who purchases or attempts to purchase a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, and who uses a driver's license, permit, Minnesota identification card, or any type of false identification to misrepresent the person's age, is guilty of a misdemeanor.

Subd. 3. **Petty misdemeanor.** Except as otherwise provided in subdivisions 1 and 2, whoever is under the age of 18 years and possesses, purchases, or attempts to purchase a product containing or delivering nicotine or lobelia intended for human consumption, or any part of such a product, that is not tobacco or an electronic delivery device as defined by section 609.685, is guilty of a petty misdemeanor.

Sec. 39. **EVALUATION AND REPORTING REQUIREMENTS.**

(a) The commissioner of health shall consult with the Alzheimer's Association, Aging Services of Minnesota, Care Providers of Minnesota, the ombudsman for long-term care, Minnesota Home Care Association, and other stakeholders to evaluate the following:

(1) whether additional settings, provider types, licensed and unlicensed personnel, or health care services regulated by the commissioner should be required to comply with the training requirements in Minnesota Statutes, sections 144D.065, 144D.10, and 144D.11;

(2) cost implications for the groups or individuals identified in clause (1) to comply with the training requirements;

(3) dementia education options available;

(4) existing dementia training mandates under federal and state statutes and rules; and

(5) the enforceability of Minnesota Statutes, sections 144D.065, 144D.10, and 144D.11, and methods to determine compliance with the training requirements.

(b) The commissioner shall report the evaluation to the chairs of the health and human services committees of the legislature no later than February 15, 2015, along with any recommendations for legislative changes.

Sec. 40. **LIMITED OPT-IN EXCEPTION.**

Parents and legal guardians of infants born prior to the effective date of this act may give the Department of Health written consent for storage and use as described in Minnesota Statutes, section 144.125, subdivisions 5 and 8.

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

Sec. 41. **DIRECTION TO COMMISSIONER; TRICLOSAN HEALTH RISKS.**

The commissioner of health shall develop recommendations on ways to minimize triclosan health risks.

Sec. 42. **REPEALER.**

(a) Minnesota Statutes 2012, section 144.125, subdivision 6, is repealed the day following final enactment.

(b) Minnesota Statutes 2012, sections 325H.06; and 325H.08, are repealed.

## ARTICLE 7

## LOCAL PUBLIC HEALTH SYSTEM

Section 1. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 1a. **Areas of public health responsibility.** "Areas of public health responsibility" means:

(1) assuring an adequate local public health infrastructure;

(2) promoting healthy communities and healthy behaviors;

(3) preventing the spread of communicable disease;

(4) protecting against environmental health hazards;

(5) preparing for and responding to emergencies; and

(6) assuring health services.

Sec. 2. Minnesota Statutes 2012, section 145A.02, subdivision 5, is amended to read:

Subd. 5. **Community health board.** "Community health board" means ~~a board of health established, operating, and eligible for a~~ the governing body for local public health ~~grant under sections 145A.09 to 145A.131.~~ in Minnesota. The community health board may be comprised of a single county, multiple contiguous counties, or in a limited number of cases, a single city as specified in section 145A.03, subdivision 1. CHBs have the responsibilities and authority under this chapter.

Sec. 3. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 6a. **Community health services administrator.** "Community health services administrator" means a person who meets personnel standards for the position established under section 145A.06, subdivision 3b, and is working under a written agreement with, employed by, or under contract with a community health board to provide public health

leadership and to discharge the administrative and program responsibilities on behalf of the board.

Sec. 4. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 8a. **Local health department.** "Local health department" means an operational entity that is responsible for the administration and implementation of programs and services to address the areas of public health responsibility. It is governed by a community health board.

Sec. 5. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 8b. **Essential public health services.** "Essential public health services" means the public health activities that all communities should undertake. These services serve as the framework for the National Public Health Performance Standards. In Minnesota they refer to activities that are conducted to accomplish the areas of public health responsibility. The ten essential public health services are to:

(1) monitor health status to identify and solve community health problems;

(2) diagnose and investigate health problems and health hazards in the community;

(3) inform, educate, and empower people about health issues;

(4) mobilize community partnerships and action to identify and solve health problems;

(5) develop policies and plans that support individual and community health efforts;

(6) enforce laws and regulations that protect health and ensure safety;

(7) link people to needed personal health services and assure the provision of health care when otherwise unavailable;

(8) maintain a competent public health workforce;

(9) evaluate the effectiveness, accessibility, and quality of personal and population-based health services; and

(10) contribute to research seeking new insights and innovative solutions to health problems.

Sec. 6. Minnesota Statutes 2012, section 145A.02, subdivision 15, is amended to read:

Subd. 15. **Medical consultant.** "Medical consultant" means a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with a community health board ~~of health~~ to provide advice

and information, to authorize medical procedures through ~~standing orders~~ protocols, and to assist a community health board ~~of health~~ and its staff in coordinating their activities with local medical practitioners and health care institutions.

Sec. 7. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 15a. **Performance management.** "Performance management" means the systematic process of using data for decision making by identifying outcomes and standards; measuring, monitoring, and communicating progress; and engaging in quality improvement activities in order to achieve desired outcomes.

Sec. 8. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 15b. **Performance measures.** "Performance measures" means quantitative ways to define and measure performance.

Sec. 9. Minnesota Statutes 2012, section 145A.03, subdivision 1, is amended to read:

Subdivision 1. **Establishment; assignment of responsibilities.** (a) The governing body of a ~~city or~~ county must undertake the responsibilities of a community health board ~~of health or establish a board of health~~ by establishing or joining a community health board according to paragraphs (b) to (f) and ~~assign~~ assigning to it the powers and duties ~~of a board of health~~ specified under section 145A.04.

(b) ~~A city council may ask a county or joint powers board of health to undertake the responsibilities of a board of health for the city's jurisdiction.~~ A community health board must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.09 to 145A.131 is preempted from forming a ~~board of~~ community health board except as specified in section ~~145A.10, subdivision 2~~ 145A.131.

(d) A county board or a joint powers board that establishes a community health board and has or establishes an operational human services board under chapter 402 may assign the powers and duties of a community health board to a human services board. Eligibility for funding from the commissioner will be maintained if all requirements of sections 145A.03 and 145A.04 are met.

(e) Community health boards established prior to January 1, 2014, including city community health boards, are eligible to maintain their status as community health boards as outlined in this subdivision.

(f) A community health board may authorize, by resolution, the community health service administrator or other designated agent or agents to act on behalf of the community health board.

Sec. 10. Minnesota Statutes 2012, section 145A.03, subdivision 2, is amended to read:

Subd. 2. **Joint powers community health board ~~of health.~~** ~~Except as preempted under section 145A.10, subdivision 2,~~ A county may establish a joint community health board ~~of health~~ by agreement with one or more contiguous counties, or ~~a~~ an existing city community health board may establish a joint community health board ~~of health~~ with one or more contiguous ~~cities in the same county, or a city may establish a joint board of health with the~~ existing city community health boards in the same county ~~or counties within~~ in which it is located. The agreements must be established according to section 471.59.

Sec. 11. Minnesota Statutes 2012, section 145A.03, subdivision 4, is amended to read:

Subd. 4. **Membership; duties of chair.** A community health board ~~of health~~ must have at least five members, one of whom must be elected by the members as chair and one as vice-chair. The chair, or in the chair's absence, the vice-chair, must preside at meetings of the community health board ~~of health~~ and sign or authorize an agent to sign contracts and other documents requiring signature on behalf of the community health board ~~of health~~.

Sec. 12. Minnesota Statutes 2012, section 145A.03, subdivision 5, is amended to read:

Subd. 5. **Meetings.** A community health board ~~of health~~ must hold meetings at least twice a year and as determined by its rules of procedure. The board must adopt written procedures for transacting business and must keep a public record of its transactions, findings, and determinations. Members may receive a per diem plus travel and other eligible expenses while engaged in official duties.

Sec. 13. Minnesota Statutes 2012, section 145A.03, is amended by adding a subdivision to read:

Subd. 7. **Community health board; eligibility for funding.** A community health board that meets the requirements of this section is eligible to receive the local public health grant under section 145A.131 and for other funds that the commissioner grants to community health boards to carry out public health activities.

Sec. 14. Minnesota Statutes 2012, section 145A.04, as amended by Laws 2013, chapter 43, section 21, is amended to read:

**145A.04 POWERS AND DUTIES OF COMMUNITY HEALTH BOARD ~~OF HEALTH~~.**

Subdivision 1. **Jurisdiction; enforcement.** (a) A ~~county or multicounty~~ community health board ~~of health~~ has the ~~powers and duties of a board of health for all territory within its jurisdiction not under the jurisdiction of a city board of health. Under the general supervision of the commissioner, the board shall enforce laws, regulations, and ordinances pertaining to the powers and duties of a board of health within its jurisdictional area~~ general responsibility for development and maintenance of a system of community health services under local administration and within a system of state guidelines and standards.

(b) Under the general supervision of the commissioner, the community health board shall recommend the enforcement of laws, regulations, and ordinances pertaining to the powers and duties within its jurisdictional area. In the case of a multicounty or city community health board, the joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07 shall clearly specify enforcement authorities.

(c) A member of a community health board may not withdraw from a joint powers community health board during the first two calendar years following the effective date of the initial joint powers agreement. The withdrawing member must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

(d) The withdrawal of a county or city from a community health board does not effect the eligibility for the local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(e) The local public health grant for a county or city that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive.

Subd. 1a. **Duties.** Consistent with the guidelines and standards established under section 145A.06, the community health board shall:

(1) identify local public health priorities and implement activities to address the priorities and the areas of public health responsibility, which include:

(i) assuring an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community

mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement;

(ii) promoting healthy communities and healthy behavior through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health;

(iii) preventing the spread of communicable disease by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks;

(iv) protecting against environmental health hazards by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances;

(v) preparing and responding to emergencies by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response; and

(vi) assuring health services by engaging in activities such as assessing the availability of health-related services and health care providers in local communities, identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process; and

(2) submit to the commissioner of health, at least every five years, a community health assessment and community health improvement plan, which shall be developed with input from the community and take into consideration the statewide outcomes, the areas of responsibility, and essential public health services;

(3) implement a performance management process in order to achieve desired outcomes; and

(4) annually report to the commissioner on a set of performance measures and be prepared to provide documentation of ability to meet the performance measures.

Subd. 2. **Appointment of ~~agent~~ community health service (CHS) administrator.** A community health board ~~of health~~ must appoint, employ, or contract with a ~~person or persons~~ CHS administrator to act on its behalf. The board shall notify the commissioner of the ~~agent's name, address, and phone number where the agent may be reached between board meetings~~ CHS administrator's contact information and submit a copy of the resolution authorizing the ~~agent~~ CHS administrator to act as an agent on the board's behalf. The resolution must specify the types of action or actions that the CHS administrator is authorized to take on behalf of the board.

Subd. 2a. **Appointment of medical consultant.** The community health board shall appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the community health board and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 3. **Employment; ~~medical consultant~~ employees.** (a) A community health board ~~of health may establish a health department or other administrative agency and~~ may employ persons as necessary to carry out its duties.

(b) Except where prohibited by law, employees of the community health board ~~of health~~ may act as its agents.

(c) ~~Employees of the board of health are subject to any personnel administration rules adopted by a city council or county board forming the board of health unless the employees of the board are within the scope of a statewide personnel administration system.~~ Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights.

~~(d) The board of health may appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.~~

Subd. 4. **Acquisition of property; request for and acceptance of funds; collection of fees.** (a) A community health board ~~of health~~ may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to 145A.131. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

(b) A community health board ~~of health~~ may accept gifts, grants, and subsidies from any lawful source, apply for and accept state and federal funds, and request and accept local tax funds.

(c) A community health board ~~of health~~ may establish and collect reasonable fees for performing its duties and providing community health services.

(d) With the exception of licensing and inspection activities, access to community health services provided by or on contract with the community health board ~~of health~~ must not be denied to an individual or family because of inability to pay.

Subd. 5. **Contracts.** To improve efficiency, quality, and effectiveness, avoid unnecessary duplication, and gain cost advantages, a community health board ~~of health~~ may contract to provide, receive, or ensure provision of services.

Subd. 6. **Investigation; reporting and control of communicable diseases.** A community health board ~~of health~~ shall make investigations, or coordinate with any county board or city council within its jurisdiction to make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Community health boards ~~of health~~ must cooperate so far as practicable to act together to prevent and control epidemic diseases.

Subd. 6a. **Minnesota Responds Medical Reserve Corps; planning.** A community health board ~~of health~~ receiving funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services shall participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of the Department of Health. A community health board ~~of health~~ shall collaborate on volunteer planning with other public and private partners, including but not limited to local or regional health care providers, emergency medical services, hospitals, tribal governments, state and local emergency management, and local disaster relief organizations.

Subd. 6b. **Minnesota Responds Medical Reserve Corps; agreements.** A community health board ~~of health~~, county, or city participating in the Minnesota Responds Medical Reserve Corps program may enter into written mutual aid agreements for deployment of its paid employees and its Minnesota Responds Medical Reserve Corps volunteers with other community health boards ~~of health~~, other political subdivisions within the state, or with tribal governments within the state. A community health board ~~of health~~ may also enter into agreements with the Indian Health Services of the United States Department of Health and Human Services, and with boards of health, political subdivisions, and tribal governments in bordering states and Canadian provinces.

Subd. 6c. **Minnesota Responds Medical Reserve Corps; when mobilized.** When a community health board ~~of health~~, county, or city finds that the prevention, mitigation, response to, or recovery from an actual or threatened public health event or emergency

exceeds its local capacity, it shall use available mutual aid agreements. If the event or emergency exceeds mutual aid capacities, a community health board ~~of health~~, county, or city may request the commissioner of health to mobilize Minnesota Responds Medical Reserve Corps volunteers from outside the jurisdiction of the community health board ~~of health~~, county, or city.

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 community health board ~~of health~~, county, or city must be deemed an employee of the jurisdiction for purposes of workers' compensation, tort claim defense, and indemnification.

Subd. 7. **Entry for inspection.** To enforce public health laws, ordinances or rules, a member or agent of a community health board ~~of health~~, county, or city may enter a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected.

Subd. 8. **Removal and abatement of public health nuisances.** (a) If a threat to the public health such as a public health nuisance, source of filth, or cause of sickness is found on any property, the community health board ~~of health~~, county, city, or its agent shall order the owner or occupant of the property to remove or abate the threat within a time specified in the notice but not longer than ten days. Action to recover costs of enforcement under this subdivision must be taken as prescribed in section 145A.08.

(b) Notice for abatement or removal must be served on the owner, occupant, or agent of the property in one of the following ways:

(1) by registered or certified mail;

(2) by an officer authorized to serve a warrant; or

(3) by a person aged 18 years or older who is not reasonably believed to be a party to any action arising from the notice.

(c) If the owner of the property is unknown or absent and has no known representative upon whom notice can be served, the community health board ~~of health~~, county, or city, or its agent, shall post a written or printed notice on the property stating that, unless the threat to the public health is abated or removed within a period not longer than ten days, the community health board, county, or city will have the threat abated or removed at the expense of the owner under section 145A.08 or other applicable state or local law.

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the community health board ~~of health~~, county, city, or ~~its~~ a designated agent of the board, county, or city shall remove or

abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the community health board ~~of health~~, county, or city may bring an action in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

Subd. 10. **Hindrance of enforcement prohibited; penalty.** It is a misdemeanor ~~deliberately~~ to deliberately hinder a member of a community health board ~~of health~~, county or city, or its agent from entering a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected, or otherwise to interfere with the performance of the duties of the ~~board of health~~ responsible jurisdiction.

Subd. 11. **Neglect of enforcement prohibited; penalty.** It is a misdemeanor for a member or agent of a community health board ~~of health~~, county, or city to refuse or neglect to perform a duty imposed on ~~a board of health~~ an applicable jurisdiction by statute or ordinance.

Subd. 12. **Other powers and duties established by law.** This section does not limit powers and duties of a community health board ~~of health~~, county, or city prescribed in other sections.

Subd. 13. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 14. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 15. **State and local advisory committees.** (a) A state community health services advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of local public health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) Notwithstanding section 15.059, the State Community Health Services Advisory Committee does not expire.

(c) The city boards or county boards that have established or are members of a community health board may appoint a community health advisory to advise, consult with, and make recommendations to the community health board on the duties under subdivision 1a.

Sec. 15. Minnesota Statutes 2012, section 145A.05, subdivision 2, is amended to read:

Subd. 2. **Animal control.** In addition to powers under sections 35.67 to 35.69, a county board, city council, or municipality may adopt ordinances to issue licenses or otherwise regulate the keeping of animals, to restrain animals from running at large, to authorize the impounding and sale or summary destruction of animals, and to establish pounds.

Sec. 16. Minnesota Statutes 2012, section 145A.06, subdivision 2, is amended to read:

Subd. 2. **Supervision of local enforcement.** (a) In the absence of provision for a community health board ~~of health~~, the commissioner may appoint three or more persons to act as a board until one is established. The commissioner may fix their compensation, which the county or city must pay.

(b) The commissioner by written order may require any two or more community health boards ~~of health~~, counties, or cities to act together to prevent or control epidemic diseases.

(c) If a community health board, county, or city fails to comply with section 145A.04, subdivision 6, the commissioner may employ medical and other help necessary to control communicable disease at the expense of the ~~board of health~~ jurisdiction involved.

(d) If the commissioner has reason to believe that the provisions of this chapter have been violated, the commissioner shall inform the attorney general and submit information to support the belief. The attorney general shall institute proceedings to enforce the provisions of this chapter or shall direct the county attorney to institute proceedings.

Sec. 17. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 3a. **Assistance to community health boards.** The commissioner shall help and advise community health boards that ask for assistance in developing, administering, and carrying out public health services and programs. This assistance may consist of, but is not limited to:

(1) informational resources, consultation, and training to assist community health boards plan, develop, integrate, provide, and evaluate community health services; and

(2) administrative and program guidelines and standards developed with the advice of the State Community Health Services Advisory Committee.

Sec. 18. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 3b. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Services Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Sec. 19. Minnesota Statutes 2012, section 145A.06, subdivision 5, is amended to read:

Subd. 5. **Deadly infectious diseases.** The commissioner shall promote measures aimed at preventing businesses from facilitating sexual practices that transmit deadly infectious diseases by providing technical advice to community health boards ~~of health~~ to assist them in regulating these practices or closing establishments that constitute a public health nuisance.

Sec. 20. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 5a. **System-level performance management.** To improve public health and ensure the integrity and accountability of the statewide local public health system, the commissioner, in consultation with the State Community Health Services Advisory Committee, shall develop performance measures and implement a process to monitor statewide outcomes and performance improvement.

Sec. 21. Minnesota Statutes 2012, section 145A.06, subdivision 6, is amended to read:

Subd. 6. **Health volunteer program.** (a) The commissioner may accept grants from the United States Department of Health and Human Services for the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b. The ESAR-VHP program as implemented in Minnesota is known as the Minnesota Responds Medical Reserve Corps.

(b) The commissioner may maintain a registry of volunteers for the Minnesota Responds Medical Reserve Corps and obtain data on volunteers relevant to possible deployments within and outside the state. All state licensing and certifying boards

shall cooperate with the Minnesota Responds Medical Reserve Corps and shall verify volunteers' information. The commissioner may also obtain information from other states and national licensing or certifying boards for health practitioners.

(c) The commissioner may share volunteers' data, including any data classified as private data, from the Minnesota Responds Medical Reserve Corps registry with community health boards ~~of health~~, cities or counties, the University of Minnesota's Academic Health Center or other public or private emergency preparedness partners, or tribal governments operating Minnesota Responds Medical Reserve Corps units as needed for credentialing, organizing, training, and deploying volunteers. Upon request of another state participating in the ESAR-VHP or of a Canadian government administering a similar health volunteer program, the commissioner may also share the volunteers' data as needed for emergency preparedness and response.

Sec. 22. Minnesota Statutes 2013 Supplement, 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~~ community health board, county, or city 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. 23. Minnesota Statutes 2012, section 145A.07, subdivision 1, is amended to read:

Subdivision 1. **Agreements to perform duties of commissioner.** (a) The commissioner of health may enter into an agreement with any community health board ~~of health~~, county, or city to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

(c) This subdivision does not affect agreements entered into under Minnesota Statutes 1986, section 145.031, 145.55, or 145.918, subdivision 2.

Sec. 24. Minnesota Statutes 2012, section 145A.07, subdivision 2, is amended to read:

Subd. 2. **Agreements to perform duties of community health board ~~of health~~.** A community health board ~~of health~~ may authorize a ~~township board,~~ city ~~council,~~ or county ~~board~~ within its jurisdiction to ~~establish a board of health under section 145A.03 and delegate to the board of health by agreement any powers or duties under sections 145A.04, 145A.07, subdivision 2, and 145A.08~~ carry out activities to fulfill community health board responsibilities. An agreement to delegate community health board powers

and duties ~~of a board of health~~ to a county or city must be approved by the commissioner ~~and is subject to subdivision 3~~.

Sec. 25. Minnesota Statutes 2012, section 145A.08, is amended to read:

**145A.08 ASSESSMENT OF COSTS; TAX LEVY AUTHORIZED.**

Subdivision 1. **Cost of care.** A person who has or whose dependent or spouse has a communicable disease that is subject to control by the community health board ~~of health~~ is financially liable to the unit or agency of government that paid for the reasonable cost of care provided to control the disease under section 145A.04, subdivision 6.

Subd. 2. **Assessment of costs of enforcement.** (a) If costs are assessed for enforcement of section 145A.04, subdivision 8, and no procedure for the assessment of costs has been specified in an agreement established under section 145A.07, the enforcement costs must be assessed as prescribed in this subdivision.

(b) A debt or claim against an individual owner or single piece of real property resulting from an enforcement action authorized by section 145A.04, subdivision 8, must not exceed the cost of abatement or removal.

(c) The cost of an enforcement action under section 145A.04, subdivision 8, may be assessed and charged against the real property on which the public health nuisance, source of filth, or cause of sickness was located. The auditor of the county in which the action is taken shall extend the cost so assessed and charged on the tax roll of the county against the real property on which the enforcement action was taken.

(d) The cost of an enforcement action taken by a town or city ~~board of health~~ under section 145A.04, subdivision 8, may be recovered from the county in which the town or city is located if the city clerk or other officer certifies the costs of the enforcement action to the county auditor as prescribed in this section. Taxes equal to the full amount of the enforcement action but not exceeding the limit in paragraph (b) must be collected by the county treasurer and paid to the city or town as other taxes are collected and paid.

Subd. 3. **Tax levy authorized.** A city council or county board that has formed or is a member of a community health board ~~of health~~ may levy taxes on all taxable property in its jurisdiction to pay the cost of performing its duties under this chapter.

Sec. 26. Minnesota Statutes 2012, section 145A.11, subdivision 2, is amended to read:

Subd. 2. **Levying taxes.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet local public health priorities established under section ~~145A.10, subdivision 5a~~ 145A.04,

subdivision 1a, clause (2), and statewide outcomes ~~established~~ under section ~~145A.12, subdivision 7~~ 145A.04, subdivision 1a, clause (1).

Sec. 27. Minnesota Statutes 2012, section 145A.131, is amended to read:

**145A.131 LOCAL PUBLIC HEALTH GRANT.**

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section ~~145A.09, subdivision 2~~ 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section ~~145A.09, subdivision 2~~ 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections ~~145A.09~~ 145A.03 to 145A.131 to achieve locally identified priorities under section ~~145A.12, subdivision 7, by July 1, 2004~~ 145A.04, subdivision 1a, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to (d).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections ~~145A.09~~ 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Accountability.** (a) Community health boards accepting local public health grants must ~~document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.~~ meet all of the requirements and perform all of the duties described in sections 145A.03 and 145A.04, to maintain eligibility to receive the local public health grant.

~~(b) In determining whether or not the community health board is documenting progress toward statewide outcomes, the commissioner shall consider the following factors:~~

~~(1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;~~

~~(2) the effort put forth by the community health board toward the selected statewide outcomes;~~

~~(3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;~~

~~(4) the amount of funding received by the community health board to address the statewide outcomes; and~~

~~(5) other factors as the commissioner may require, if the commissioner specifically identifies the additional factors in the commissioner's written notice of determination.~~

~~(c) If the commissioner determines that a community health board has not by the applicable deadline documented progress toward the selected statewide outcomes established under section 145.8821 or 145A.12, subdivision 7, the commissioner shall notify the community health board in writing and recommend specific actions that the community health board should take over the following 12 months to maintain eligibility for the local public health grant.~~

~~(d) During the 12 months following the written notification, the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in the written notification.~~

~~(e) If the community health board has not taken the specific actions recommended by the commissioner within 12 months following written notification, the commissioner may~~

~~determine not to distribute funds to the community health board under section 145A.12, subdivision 2, for the next fiscal year.~~

~~(f) If the commissioner determines not to distribute funds for the next fiscal year, the commissioner must give the community health board written notice of this determination and allow the community health board to appeal the determination in writing.~~

~~(g) If the commissioner determines not to distribute funds for the next fiscal year to a community health board that has not documented progress toward the statewide outcomes and not taken the actions recommended by the commissioner, the commissioner may retain local public health grant funds that the community health board would have otherwise received and directly carry out essential local activities to meet the statewide outcomes, or contract with other units of government or community-based organizations to carry out essential local activities related to the statewide outcomes.~~

~~(h) If the community health board that does not document progress toward the statewide outcomes is a city, the commissioner shall distribute the local public health funds that would have been allocated to that city to the county in which the city is located, if that county is part of a community health board.~~

~~(i) The commissioner shall establish a reporting system by which community health boards will document their progress toward statewide outcomes. This system will be developed in consultation with the State Community Health Services Advisory Committee established in section 145A.10, subdivision 10, paragraph (a).~~

(b) By January 1 of each year, the commissioner shall notify community health boards of the performance-related accountability requirements of the local public health grant for that calendar year. Performance-related accountability requirements will be comprised of a subset of the annual performance measures and will be selected in consultation with the State Community Health Services Advisory Committee.

(c) If the commissioner determines that a community health board has not met the accountability requirements, the commissioner shall notify the community health board in writing and recommend specific actions the community health board must take over the next six months in order to maintain eligibility for the Local Public Health Act grant.

(d) Following the written notification in paragraph (c), the commissioner shall provide administrative and program support to assist the community health board as required in section 145A.06, subdivision 3a.

(e) The commissioner shall provide the community health board two months following the written notification to appeal the determination in writing.

(f) If the community health board has not submitted an appeal within two months or has not taken the specific actions recommended by the commissioner within six

months following written notification, the commissioner may elect to not reimburse invoices for funds submitted after the six-month compliance period and shall reduce by 1/12 the community health board's annual award allocation for every successive month of noncompliance.

(g) The commissioner may retain the amount of funding that would have been allocated to the community health board and assume responsibility for public health activities in the geographic area served by the community health board.

Subd. 4. **Responsibility of commissioner to ensure a statewide public health system.** ~~If a county withdraws from a community health board and operates as a board of health or~~ If a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board ~~using the formula described in subdivision 1~~ and assume responsibility for public health activities ~~to meet the statewide outcomes~~ in the geographic area served ~~by the board of health or community health board~~. The commissioner may elect to directly provide public health activities ~~to meet the statewide outcomes~~ or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located~~, if the county is part of a community health board~~.

Subd. 5. ~~**Local public health priorities**~~ **Use of funds.** Community health boards may use their local public health grant ~~to address local public health priorities identified under section 145A.10, subdivision 5a.~~ funds to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

Sec. 28. **REVISOR'S INSTRUCTION.**

(a) The revisor shall change the terms "board of health" or "local board of health" or any derivative of those terms to "community health board" where it appears in Minnesota Statutes, sections 13.3805, subdivision 1, paragraph (b); 13.46, subdivision 2, paragraph (a), clause (24); 35.67; 35.68; 38.02, subdivision 1, paragraph (b), clause (1); 121A.15, subdivisions 7 and 8; 144.055, subdivision 1; 144.065; 144.12, subdivision 1; 144.255, subdivision 2a; 144.3351; 144.383; 144.417, subdivision 3; 144.4172, subdivision 6; 144.4173, subdivision 2; 144.4174; 144.49, subdivision 1; 144.6581; 144A.471, subdivision 9, clause (19); 145.9255, subdivision 2; 175.35; 308A.201, subdivision 14; 375A.04, subdivision 1; and 412.221, subdivision 22, paragraph (c).

(b) The revisor shall change the cross-reference from "145A.02, subdivision 2" to "145A.02, subdivision 5" where it appears in Minnesota Statutes, sections 13.3805, subdivision 1, paragraph (b); 13.46, subdivision 2, paragraph (a), clause (24); 35.67; 35.68; 38.02, subdivision 1, paragraph (b), clause (1); 121A.15, subdivisions 7 and 8; 144.055, subdivision 1; 144.065; 144.12, subdivision 1; 144.225, subdivision 2a; 144.3351; 144.383; 144.417, subdivision 3; 144.4172, subdivision 6; 144.4173, subdivision 2; 144.4174; 144.49, subdivision 1; 144A.471, subdivision 9, clause (19); 175.35; 308A.201, subdivision 14; 375A.04, subdivision 1; and 412.221, subdivision 22, paragraph (c).

Sec. 29. **REPEALER.**

Minnesota Statutes 2012, sections 145A.02, subdivision 2; 145A.03, subdivisions 3 and 6; 145A.09, subdivisions 1, 2, 3, 4, 5, and 7; 145A.10, subdivisions 1, 2, 3, 4, 5a, 7, 9, and 10; and 145A.12, subdivisions 1, 2, and 7, are repealed. The revisor shall remove cross-references to these repealed sections and make changes necessary to correct punctuation, grammar, or structure of the remaining text.

## ARTICLE 8

## CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 245A.155, subdivision 1, is amended to read:

Subdivision 1. **Licensed foster care and respite care.** This section applies to foster care agencies and licensed foster care providers who place, supervise, or care for individuals who rely on medical monitoring equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment in respite care or foster care.

Sec. 2. Minnesota Statutes 2012, section 245A.155, subdivision 2, is amended to read:

Subd. 2. **Foster care agency requirements.** In order for an agency to place an individual who relies on medical equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment with a foster care provider, the agency must ensure that the foster care provider has received the training to operate such equipment as observed and confirmed by a qualified source, and that the provider:

(1) is currently caring for an individual who is using the same equipment in the foster home; or

(2) has written documentation that the foster care provider has cared for an individual who relied on such equipment within the past six months; or

(3) has successfully completed training with the individual being placed with the provider.

Sec. 3. Minnesota Statutes 2012, section 245A.155, subdivision 3, is amended to read:

Subd. 3. **Foster care provider requirements.** A foster care provider shall not care for an individual who relies on medical equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment unless the provider has received the training to operate such equipment as observed and confirmed by a qualified source, and:

(1) is currently caring for an individual who is using the same equipment in the foster home; or

(2) has written documentation that the foster care provider has cared for an individual who relied on such equipment within the past six months; or

(3) has successfully completed training with the individual being placed with the provider.

Sec. 4. Minnesota Statutes 2012, section 245A.65, subdivision 2, is amended to read:

Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

(a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

(1) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.

(2) The assessment of the physical plant where the licensed services are provided shall include an evaluation of the following factors: the condition and design of the building as it relates to the safety of the clients; and the existence of areas in the building which are difficult to supervise.

(3) The assessment of the environment for each facility and for each site when living arrangements are provided by the agency shall include an evaluation of the following factors: the location of the program in a particular neighborhood or community; the type of grounds and terrain surrounding the building; the type of internal programming; and the program's staffing patterns.

(4) The license holder shall provide an orientation to the program abuse prevention plan for clients receiving services. If applicable, the client's legal representative must be notified of the orientation. The license holder shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

(5) The license holder's governing body or the governing body's delegated representative shall review the plan at least annually using the assessment factors in the plan and any substantiated maltreatment findings that occurred since the last review. The governing body or the governing body's delegated representative shall revise the plan, if necessary, to reflect the review results.

(6) A copy of the program abuse prevention plan shall be posted in a prominent location in the program and be available upon request to mandated reporters, persons receiving services, and legal representatives.

(b) In addition to the requirements in section 626.557, subdivision 14, the individual abuse prevention plan shall meet the requirements in clauses (1) and (2).

(1) The plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the individual abuse prevention plan shall document this determination.

(2) An individual abuse prevention plan shall be developed for each new person as part of the initial individual program plan or service plan required under the applicable licensing rule. The review and evaluation of the individual abuse prevention plan shall be done as part of the review of the program plan or service plan. The person receiving services shall participate in the development of the individual abuse prevention plan to the full extent of the person's abilities. If applicable, the person's legal representative shall be

given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team shall document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Sec. 5. Minnesota Statutes 2013 Supplement, section 245D.02, is amended by adding a subdivision to read:

Subd. 37. **Working day.** "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday, excluding any legal holiday.

Sec. 6. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1, is amended to read:

Subdivision 1. **Health needs.** (a) The license holder is responsible for meeting health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for ~~promptly~~ notifying the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting health service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, ~~when~~ within 24 hours of being discovered ~~by the license holder~~, or as directed in the coordinated service and support plan or support plan addendum, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication assistance or medication administration according to this chapter;

(2) monitor health conditions according to written instructions from a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Sec. 7. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1b, is amended to read:

Subd. 1b. **Medication assistance.** If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, ~~the license holder must ensure that the requirements of subdivision 2, paragraph (b), have been met when staff provides~~ medication assistance must be provided to enable a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person. For the purposes of this subdivision, "medication assistance" means any of the following:

(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person;

(2) bringing to the person liquids or food to accompany the medication; or

(3) providing reminders, in person, remotely, or through programming devices such as telephones, alarms, or medication boxes, to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

Sec. 8. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 1, is amended to read:

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported, or as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum. An incident of suspected or alleged maltreatment must be reported as required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) The license holder must report the death or serious injury of the person as required in paragraph (b) and to the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a, within 24 hours of the death or serious injury, or receipt of information that the death or serious injury occurred, unless the license holder has reason to know that the death or serious injury has already been reported.

(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death or serious injury has already been reported.

(g) The license holder must conduct an internal review of incident reports of deaths and serious injuries that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. The review must include an evaluation of whether related policies and procedures were followed, whether the policies and procedures were adequate, whether there is a need for additional staff training, whether the reported event is similar to past events with the persons or the services involved, and whether there is a need for corrective action by the license holder to protect the health and safety of persons receiving services. Based on the results of this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

(h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061.

Sec. 9. Minnesota Statutes 2013 Supplement, section 245D.07, subdivision 2, is amended to read:

Subd. 2. **Service planning requirements ~~for basic support services.~~** (a) License holders providing basic support services or intensive support services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), must meet the requirements of this subdivision.

(b) Within 15 calendar days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(c) Within 60 calendar days of service initiation the license holder must review and revise as needed the preliminary coordinated service and support plan addendum to document the services that will be provided including how, when, and by whom services will be provided, and the person responsible for overseeing the delivery and coordination of services.

(d) The license holder must participate in service planning and support team meetings for the person following stated timelines established in the person's coordinated service and support plan or as requested by the person or the person's legal representative, the support team or the expanded support team.

Sec. 10. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1 and 3.

Sec. 11. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 calendar days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within 45 calendar days of service initiation the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to assess and determine the following based on the person's coordinated service and support plan and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the same person to ensure continuity of care for the person.

(c) Within the scope of services, the license holder must, at a minimum, assess the following areas:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.

The assessments must produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.

Sec. 12. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 4, is amended to read:

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the 45-day meeting, the license holder must develop and document the service outcomes and supports based on the assessments completed under subdivision 3 and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the coordinated service and support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the accomplishment of outcomes related to acquiring, retaining, or improving skills. The documentation must include:

(1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:

(i) any changes or modifications to the physical and social environments necessary when the service supports are provided;

(ii) any equipment and materials required; and

(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day meeting, the license holder must submit to and obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and coordinated service and support plan addendum. If, within ten working days of the submission of the assessment or coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the assessment and coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the assessment and coordinated service and support plan addendum become effective and remain in effect until the legal representative or case manager submits a written request to revise the assessment or coordinated service and support plan addendum.

Sec. 13. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Progress reviews.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in progress review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a

written request by the person, the person's legal representative, or the case manager, at a minimum of once per year.

(b) The license holder must summarize the person's progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 ~~in a written report sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the~~ in a report available at the time of the progress review meeting. The report must be sent five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum. Within 60 calendar days of service initiation, the license holder must document the preference of the person or the person's legal representative and the case manager regarding receiving written reports. The license holder must document changes to those preferences when changes are requested.

(c) Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

(d) If, within ten working days of the submission of the changes to the coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan.

Sec. 14. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 3, is amended to read:

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated service and support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and the needs of the general population of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing ~~and~~ or observed skill assessment ~~conducted by the trainer or instructor~~; and

(3) except for a license holder who is the sole direct support staff, periodic performance evaluations completed by the license holder of the direct support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Sec. 15. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 4, is amended to read:

Subd. 4. **Orientation to program requirements.** Except for a license holder who does not supervise any direct support staff, within 60 calendar days of hire, unless stated otherwise, the license holder must provide and ensure completion of ten hours of orientation for direct support staff providing basic services and 30 hours of orientation for direct support staff providing intensive services that combines supervised on-the-job training with review of and instruction in the following areas:

(1) the job description and how to complete specific job functions, including:

(i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and

(ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;

(2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;

(3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;

(4) the service recipient rights and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04;

(5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This orientation must be provided within 72 hours of first providing direct contact services and annually thereafter according to section 245A.65, subdivision 3;

(6) the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person; ~~and~~

(7) the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 and what constitutes the use of restraints, time out, and seclusion, including chemical restraint;

(8) staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe;

(9) basic first aid; and

(10) other topics as determined necessary in the person's coordinated service and support plan by the case manager or other areas identified by the license holder.

Sec. 16. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 4a, is amended to read:

Subd. 4a. **Orientation to individual service recipient needs.** (a) Before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support, or any time the plans or procedures identified in paragraphs (b) to ~~(f)~~ (e) are revised, the staff person must review and receive instruction on the requirements in paragraphs (b) to ~~(f)~~ (e) as they relate to the staff person's job functions for that person.

(b) For community residential services, training and competency evaluations must include the following, if identified in the coordinated service and support plan:

(1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) as defined under section 256B.0659, subdivision 1;

(2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet; and

(3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section 256B.0659, subdivision 1~~; and~~

~~(4) demonstrated competence in providing first aid~~.

(c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.

(d) The staff person must review and receive instruction on medication administration procedures established for the person when medication administration is assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(1) specialized or intensive medical or nursing supervision; and

(2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life-threatening without proper use of the medical equipment, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) ~~The staff person must review and receive instruction on what constitutes use of restraints, time out, and seclusion, including chemical restraint, and staff responsibilities related to the prohibitions of their use according to the requirements in section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms~~

~~or undesired behavior and why they are not safe, and the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061.~~

~~(g)~~ In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

~~(h)~~ (g) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to ~~(7)~~ (10).

Sec. 17. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 5, is amended to read:

Subd. 5. **Annual training.** A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to ~~(7), and subdivision 4a~~ (10). A license holder must provide a minimum of 24 hours of annual training to direct service staff ~~with~~ providing intensive services and having fewer than five years of documented experience and 12 hours of annual training to direct service staff ~~with~~ providing intensive services and having five or more years of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to ~~(h)~~ (g). Training on relevant topics received from sources other than the license holder may count toward training requirements. A license holder must provide a minimum of 12 hours of annual training to direct service staff providing basic services and having fewer than five years of documented experience and six hours of annual training to direct service staff providing basic services and having five or more years of documented experience.

Sec. 18. Minnesota Statutes 2013 Supplement, section 245D.095, subdivision 3, is amended to read:

Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of current services provided to each person on the premises where the services are provided or coordinated. When the services are provided in a licensed facility, the records must be maintained at the facility, otherwise the records must be maintained at the license holder's program office. The license holder must protect service recipient records against loss, tampering, or unauthorized disclosure according to the requirements in sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) an admission form signed by the person or the person's legal representative that includes:

(i) identifying information, including the person's name, date of birth, address, and telephone number; and

(ii) the name, address, and telephone number of the person's legal representative, if any, and a primary emergency contact, the case manager, and family members or others as identified by the person or case manager;

(2) service information, including service initiation information, verification of the person's eligibility for services, documentation verifying that services have been provided as identified in the coordinated service and support plan or coordinated service and support plan addendum according to paragraph (a), and date of admission or readmission;

(3) health information, including medical history, special dietary needs, and allergies, and when the license holder is assigned responsibility for meeting the person's health service needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment and a signed authorization from the person or the person's legal representative to administer or assist in administering the medication or treatments, if applicable;

(ii) a signed statement authorizing the license holder to act in a medical emergency when the person's legal representative, if any, cannot be reached or is delayed in arriving;

(iii) medication administration procedures;

(iv) a medication administration record documenting the implementation of the medication administration procedures, and the medication administration record reviews, including any agreements for administration of injectable medications by the license holder according to the requirements in section 245D.05; and

(v) a medical appointment schedule when the license holder is assigned responsibility for assisting with medical appointments;

(4) the person's current coordinated service and support plan or that portion of the plan assigned to the license holder;

(5) copies of the ~~individual abuse prevention plan and~~ assessments as required under section 245D.071, ~~subdivisions 2 and~~ subdivision 3;

(6) a record of other service providers serving the person when the person's coordinated service and support plan or coordinated service and support plan addendum identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds, according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports involving the person, required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3, progress review reports as required under section 245D.071, subdivision 5, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Sec. 19. Minnesota Statutes 2013 Supplement, section 245D.22, subdivision 4, is amended to read:

Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid must be available on site and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, be able to provide cardiopulmonary resuscitation, whenever persons are present and staff are required to be at the site to provide direct service. The CPR training must include ~~in-person~~ instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor.

(b) A facility must have first aid kits readily available for use by, and that meet the needs of, persons receiving services and staff. At a minimum, the first aid kit must be equipped with accessible first aid supplies including bandages, sterile compresses, scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and first aid manual.

Sec. 20. Minnesota Statutes 2013 Supplement, section 245D.31, subdivision 3, is amended to read:

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team, must determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving

services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 ~~recorded on a standard assessment form required by the commissioner~~.

Sec. 21. Minnesota Statutes 2013 Supplement, section 245D.31, subdivision 4, is amended to read:

Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a staff ratio requirement of one to four if:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, ambulating; or ~~is not capable of taking appropriate action for self-preservation under emergency conditions; or~~

(2) the person engages in conduct that poses an imminent risk of physical harm to self or others at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in the person's coordinated service and support plan or coordinated service and support plan addendum.

Sec. 22. Minnesota Statutes 2013 Supplement, section 245D.31, subdivision 5, is amended to read:

Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a staff ratio requirement of one to eight if:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least ~~four~~ three of the following activities: toileting, communicating basic needs, eating, or ambulating~~, or taking appropriate action for self-preservation under emergency conditions~~.

Sec. 23. Minnesota Statutes 2012, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting. ~~When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. This rate reduction is effective July 1, 2013. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.~~

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

Sec. 24. Minnesota Statutes 2012, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs~~; and~~.

~~(6) for each personal care assistant, whether or not the personal care assistant is providing care to a relative as defined in subdivision 11.~~

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

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

Sec. 25. Minnesota Statutes 2013 Supplement, section 256B.0922, subdivision 1, is amended to read:

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed $400 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) caregiver support;

(ii) adult day services;

~~(ii)~~ (iii) homemaker support;

~~(iii)~~ (iv) chores;

~~(iv)~~ (v) a personal emergency response device or system;

~~(v)~~ (vi) home-delivered meals; or

~~(vi)~~ (vii) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their community support plan.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 26. Minnesota Statutes 2013 Supplement, section 256B.4912, subdivision 10, is amended to read:

Subd. 10. **Enrollment requirements.** ~~All~~ (a) Except as provided in paragraph (b), the following home and community-based waiver providers must provide, at the time of enrollment and within 30 days of a request, in a format determined by the commissioner, information and documentation that includes~~, but is not limited to, the following:~~

~~(1) proof of surety bond coverage in the amount of $50,000 or ten percent of the provider's payments from Medicaid in the previous calendar year, whichever is greater;~~

~~(2) proof of fidelity bond coverage in the amount of $20,000; and~~

~~(3)~~ proof of liability insurance~~.~~:

(1) waiver services providers required to meet the provider standards in chapter 245D;

(2) foster care providers whose services are funded by the elderly waiver or alternative care program;

(3) fiscal support entities;

(4) adult day care providers;

(5) providers of customized living services; and

(6) residential care providers.

(b) Providers of foster care services covered by section 245.814 are exempt from this subdivision.

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

Sec. 27. Minnesota Statutes 2013 Supplement, section 256B.492, is amended to read:

**256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.**

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care or child foster care setting of up to five people or community residential setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS Program;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Sec. 28. Minnesota Statutes 2012, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community residential settings licensed under chapter 245D, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings.

Sec. 29. Minnesota Statutes 2012, section 256D.01, subdivision 1e, is amended to read:

Subd. 1e. **Rules regarding emergency assistance.** The commissioner shall adopt rules under the terms of sections 256D.01 to 256D.21 for general assistance, to require use of the emergency program under MFIP as the primary financial resource when available. The commissioner shall adopt rules for eligibility for general assistance of persons with seasonal income and may attribute seasonal income to other periods not in excess of one year from receipt by an applicant or recipient. General assistance payments may not be made for foster care, community residential settings licensed under chapter 245D, child welfare services, or other social services. Vendor payments and vouchers may be issued only as authorized in sections 256D.05, subdivision 6, and 256D.09.

Sec. 30. Minnesota Statutes 2012, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, community residential setting licensed under chapter 245D, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined

in section 268A.01; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

(3) any placement for a person with an indeterminate commitment, including independent living.

Sec. 31. Minnesota Statutes 2012, section 256I.03, subdivision 3, is amended to read:

Subd. 3. **Group residential housing.** "Group residential housing" means a group living situation that provides at a minimum room and board to unrelated persons who meet the eligibility requirements of section 256I.04. This definition includes foster care settings or community residential settings for a single adult. To receive payment for a group residence rate, the residence must meet the requirements under section 256I.04, subdivision 2a.

Sec. 32. Minnesota Statutes 2012, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required.** A county agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a residential care home; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; ~~or~~ (iii) a residence licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed by the commissioner of human services under chapter 245D;

(3) the establishment is registered under chapter 144D and provides three meals a day, or is an establishment voluntarily registered under section 144D.025 as a supportive housing establishment; or

(4) an establishment voluntarily registered under section 144D.025, other than a supportive housing establishment under clause (3), is not eligible to provide group residential housing.

The requirements under clauses (1) to (4) do not apply to establishments exempt from state licensure because they are located on Indian reservations and subject to tribal health and safety requirements.

Sec. 33. Minnesota Statutes 2013 Supplement, 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, 2014~~ no sooner than January 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 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.

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

Sec. 34. Laws 2011, First Special Session chapter 9, article 7, section 7, the effective date, is amended to read:

**EFFECTIVE DATE.** This section is effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children ~~age 16 to~~ before the child's 21st birthday.

Sec. 35. Laws 2013, chapter 108, article 7, section 60, is amended to read:

Sec. 60. **PROVIDER RATE AND GRANT INCREASE EFFECTIVE APRIL 1, 2014.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by one percent for the rate period beginning April 1, 2014, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service, formerly funded under Minnesota Statutes 2010, chapter 256M;

(10) alternative care services under Minnesota Statutes, section 256B.0913, and essential community supports under Minnesota Statutes, section 256B.0922;

(11) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256M;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) housing access grants under Minnesota Statutes, sections 256B.0658 and 256B.0917, subdivision 14;

(16) self-advocacy grants under Laws 2009, chapter 101;

(17) technology grants under Laws 2009, chapter 79;

(18) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928; and

(19) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9; and Laws 1997, First Special Session chapter 5, section 20.

(c) A managed care plan receiving state payments for the services in this section must include these increases in their payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the specified services for the period beginning April 1, 2014.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

**EFFECTIVE DATE.** This section is effective retroactively from April 1, 2014.

Sec. 36. **AUTISM SPECTRUM DISORDER STATEWIDE STRATEGIC PLAN IMPLEMENTATION.**

The autism spectrum disorder statewide strategic plan developed by the Minnesota Legislative Autism Spectrum Disorder Task Force shall be implemented collaboratively by the commissioners of education, employment and economic development, health, and human services. The commissioners shall:

(1) work across state agencies and with key stakeholders to implement the strategic plan;

(2) prepare progress reports on the implementation of the plan twice per year and make the progress reports available to the public; and

(3) provide two opportunities per year for interested parties, including, but not limited to, individuals with autism, family members of individuals with autism spectrum disorder, underserved and diverse communities impacted by autism spectrum disorder, medical professionals, health plans, service providers, and schools, to provide input on the implementation of the strategic plan.

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

Sec. 37. **REPEALER.**

(a) Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 2, is repealed.

(b) Laws 2011, First Special Session chapter 9, article 6, section 95, subdivisions 1, 2, 3, and 4, are repealed effective the day following final enactment.

## ARTICLE 9

## HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256B.0654, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) "Complex ~~private duty~~ home care nursing ~~care~~" means home care nursing services provided to recipients who ~~are ventilator dependent or for whom a physician has certified that the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care~~ meet the criteria for regular home care nursing and require life-sustaining interventions to reduce the risk of long-term injury or death.

(b) "~~Private duty~~ Home care nursing" means ongoing ~~professional~~ physician-ordered hourly nursing services ~~by a registered or licensed practical nurse including assessment, professional nursing tasks, and education, based on an assessment and physician orders to maintain or restore optimal health of the recipient.~~ performed by a registered nurse or licensed practical nurse within the scope of practice as defined by the Minnesota Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a person's health.

(c) "~~Private duty~~ Home care nursing agency" means a medical assistance enrolled provider licensed under chapter 144A to provide ~~private duty~~ home care nursing services.

(d) "Regular ~~private duty~~ home care nursing" means ~~nursing services provided to a recipient who is considered stable and not at an inpatient hospital intensive care unit level of care, but may have episodes of instability that are not life threatening~~ home care nursing provided because:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(e) "Shared ~~private duty~~ home care nursing" means the provision of home care nursing services by a ~~private duty~~ home care nurse to two recipients at the same time and in the same setting.

**EFFECTIVE DATE.** This section is effective July 1, 2014.

Sec. 2. Minnesota Statutes 2012, section 256B.0751, is amended by adding a subdivision to read:

Subd. 10. **Health care homes advisory committee.** (a) The commissioners of health and human services shall establish a health care homes advisory committee to advise the commissioners on the ongoing statewide implementation of the health care homes program authorized in this section.

(b) The commissioners shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; mental health providers; nursing and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes.

(c) The advisory committee shall advise the commissioners on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care home evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care home rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care home subject matter task forces or workgroups; and

(7) other related issues as requested by the commissioners.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

Sec. 3. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision to read:

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b) shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek individual county's input regarding the respondent's network of health care providers;

(2) organize counties into regional groups, or single counties for the largest and most diverse counties, and seek each regional group's or county's input regarding the respondent's ability to fully and adequately deliver required health care services; and

(3) use a scoring system for evaluating respondents that at least considers:

(i) the degree to which a respondent's health care provider network is contracted through total-cost-of-care contracts, risk-sharing arrangements, or other payment reforms designed to generate long-term savings;

(ii) the degree to which a respondent has demonstrated mechanisms and processes to achieve integration of medical care, behavioral health care, and county social services, taking into account county input on the respondent's performance on these measures;

(iii) the degree to which a respondent has a comprehensive quality program that is designed to ensure enrollee access to appropriate, high-quality, coordinated services;

(iv) each county's input regarding a respondent's network of health care providers;

(v) the demonstrated ability to respond to the needs of special populations within that geographic area and to have sufficient capacity to serve populations with unique language, cultural, or other needs;

(vi) the degree to which the respondent is willing to commit to sufficient capacity in its network to meet the demand for evening and weekend appointments for populations unable to leave work for basic primary care;

(vii) regional county group's input regarding a respondent's ability to fully and adequately deliver required health care services;

(viii) a respondent's past performance on administrative requirements;

(ix) a respondent's ability to assist an enrollee who may be transitioning between public health care programs and premium tax credits in the individual insurance market;

(x) the total cost of a respondent's proposal; and

(xi) any other criteria that the commissioner finds necessary to ensure compliance with federal law or to ensure that enrollees receive high-quality health care.

Sec. 4. Minnesota Statutes 2013 Supplement, section 256B.766, is amended to read:

**256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics

and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(g) Effective January 1, 2015, for purposes of this section, "basic care services" means: ambulatory surgical center facility services, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, eyeglasses and contacts not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, outpatient hospital facility services, and anesthesia services. For purposes of medical assistance and MinnesotaCare payment adjustments effective on or after January 1, 2015, the commissioner shall not classify medical supplies, durable medical equipment, prosthetics, and orthotics in any service category other than basic care services.

Sec. 5. **DIRECTION TO COMMISSIONER; STRATEGIES TO ADDRESS CHRONIC CONDITIONS.**

The commissioner of human services shall incorporate strategies and activities in the Department of Human Service's planning efforts and design of the state Medicaid plan option under section 2703 of the Patient Protection and Affordable Care Act that address chronic medical or behavioral health conditions complicated by socioeconomic factors such as race, ethnicity, age, immigration, or language.

Sec. 6. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the term "private duty nursing" or similar terms to "home care nursing" or similar terms, and shall change the term "private duty nurse" to "home care nurse," wherever these terms appear in Minnesota Statutes and Minnesota Rules. The revisor shall also make grammatical changes related to the changes in terms.

## ARTICLE 10

## MISCELLANEOUS

Section 1. Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon

request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, ~~the provider agency~~ durable medical equipment providers and suppliers defined in clause (3) must purchase a ~~performance~~ surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a ~~performance~~ surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a ~~performance~~ surety bond of $100,000. The ~~performance~~ surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a ~~performance~~ surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The ~~performance~~ surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The ~~performance~~ surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider already maintains a surety bond that meets the specifications of another surety bond requirement in this chapter.

Sec. 2. Minnesota Statutes 2013 Supplement, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the

provider agency must purchase a ~~performance~~ surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a ~~performance~~ surety bond of $100,000. The ~~performance~~ surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services

for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare

as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Sec. 3. Minnesota Statutes 2012, section 256B.5016, subdivision 1, is amended to read:

Subdivision 1. **Managed care pilot.** The commissioner may initiate a capitated risk-based managed care option for services in an intermediate care facility for persons with developmental disabilities according to the terms and conditions of the federal agreement governing the managed care pilot. The commissioner may grant a variance to any of the provisions in sections 256B.501 to 256B.5015 and Minnesota Rules, parts 9525.1200 to 9525.1330 ~~and 9525.1580~~.

Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 16, is amended to read:

Subd. 16. **Project extension.** Minnesota Rules, parts 9500.1450; 9500.1451; 9500.1452; 9500.1453; 9500.1454; 9500.1455; ~~9500.1456;~~ 9500.1457; 9500.1458; 9500.1459; 9500.1460; 9500.1461; 9500.1462; 9500.1463; and 9500.1464$_2$ are extended.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS provider agencies.** (a) All CFSS provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider agency's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the provider agency must purchase a ~~performance~~ surety bond of $50,000. If the provider agency's Medicaid revenue in the previous calendar year is greater than $300,000, the provider agency must purchase a ~~performance~~ surety bond of $100,000. The ~~performance~~ surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the CFSS provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the CFSS provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS provider agency's time sheet if the time sheet varies from the standard time sheet for CFSS services approved by the commissioner, and a letter requesting approval of the CFSS provider agency's nonstandard time sheet; and

(ii) the CFSS provider agency's template for the CFSS care plan;

(9) a list of all training and classes that the CFSS provider agency requires of its staff providing CFSS services;

(10) documentation that the CFSS provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for employee personal care assistant wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the support specialist and the reasonable costs associated with the support specialist shall not be used in making this calculation; and

(14) documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular CFSS recipient or for another CFSS provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS provider agencies shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners

who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS provider agency billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. CFSS provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision.

Sec. 6. Minnesota Statutes 2012, section 393.01, subdivision 2, is amended to read:

Subd. 2. **Selection of members, terms, vacancies.** Except in counties which contain a city of the first class and counties having a poor and hospital commission, the local social services agency shall consist of seven members, including the board of county commissioners, to be selected as herein provided; two members, one of whom shall be a woman, shall be appointed by the ~~commissioner of human services~~ board of county commissioners, one each year for a full term of two years, from a list of residents~~, submitted by the board of county commissioners~~. As each term expires or a vacancy occurs by reason of death or resignation, a successor shall be appointed by the ~~commissioner of human services~~ board of county commissioners for the full term of two years or the balance of any unexpired term from a list of one or more, not to exceed three residents ~~submitted by the board of county commissioners~~. The board of county commissioners may, by resolution adopted by a majority of the board, determine that only three of their members shall be members of the local social services agency, in which event the local social services agency shall consist of five members instead of seven. When a vacancy occurs on the local social services agency by reason of the death, resignation, or expiration of the term of office of a member of the board of county commissioners, the unexpired term of such member shall be filled by appointment by the county commissioners. Except to fill a vacancy the term of office of each member of the local social services agency shall commence on the first Thursday after the first Monday in July, and continue until the expiration of the term for which such member was appointed or until a successor is appointed and qualifies. ~~If the board of county commissioners shall refuse, fail, omit, or neglect to submit one or more nominees to the commissioner of human services for appointment to the local social services agency by the commissioner of human services, as herein provided, or to appoint the three members to the local social services agency, as herein provided, by the time when the terms of such members commence, or, in the event of vacancies, for a~~

~~period of 30 days thereafter, the commissioner of human services is hereby empowered to and shall forthwith appoint residents of the county to the local social services agency. The commissioner of human services, on refusing to appoint a nominee from the list of nominees submitted by the board of county commissioners, shall notify the county board of such refusal. The county board shall thereupon nominate additional nominees. Before the commissioner of human services shall fill any vacancy hereunder resulting from the failure or refusal of the board of county commissioners of any county to act, as required herein, the commissioner of human services shall mail 15 days' written notice to the board of county commissioners of its intention to fill such vacancy or vacancies unless the board of county commissioners shall act before the expiration of the 15-day period.~~

Sec. 7. Minnesota Statutes 2012, section 393.01, subdivision 7, is amended to read:

Subd. 7. **Joint exercise of powers.** Notwithstanding the provisions of subdivision 1 two or more counties may by resolution of their respective boards of county commissioners, agree to combine the functions of their separate local social services agency into one local social services agency to serve the two or more counties that enter into the agreement. Such agreement may be for a definite term or until terminated in accordance with its terms. When two or more counties have agreed to combine the functions of their separate local social services agency, a single local social services agency in lieu of existing individual local social services agency shall be established to direct the activities of the combined agency. This agency shall have the same powers, duties and functions as an individual local social services agency. The single local social services agency shall have representation from each of the participating counties with selection of the members to be as follows:

(a) Each board of county commissioners entering into the agreement shall on an annual basis select one or two of its members to serve on the single local social services agency.

(b) Each board of county commissioners entering into the agreement shall ~~in accordance with procedures established by the commissioner of human services, submit a list of names of three county residents, who shall not be county commissioners, to the commissioner of human services. The commissioner shall~~ select one ~~person from each county list~~ county resident who is not a county commissioner to serve as a local social services agency member.

(c) The composition of the agency may be determined by the boards of county commissioners entering into the agreement providing that no less than one-third of the members are appointed as provided in ~~clause~~ paragraph (b).

Sec. 8. Laws 2011, First Special Session chapter 9, article 9, section 17, is amended to read:

Sec. 17. **SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT PROCESS.**

(a) The commissioner of human services shall issue a request for information for an integrated service delivery system for health care programs, food support, cash assistance, and child care. The commissioner shall determine, in consultation with partners in paragraph (c), if the products meet departments' and counties' functions. The request for information may incorporate a performance-based vendor financing option in which the vendor shares the risk of the project's success. The health care system must be developed in phases with the capacity to integrate food support, cash assistance, and child care programs as funds are available. The request for information must require that the system:

(1) streamline eligibility determinations and case processing to support statewide eligibility processing;

(2) enable interested persons to determine eligibility for each program, and to apply for programs online in a manner that the applicant will be asked only those questions relevant to the programs for which the person is applying;

(3) leverage technology that has been operational in other state environments with similar requirements; and

(4) include Web-based application, worker application processing support, and the opportunity for expansion.

(b) The commissioner shall issue a final report, including the implementation plan, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services no later than January 31, 2012.

(c) The commissioner shall partner with counties, a service delivery authority established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology, other state agencies, and service partners to develop an integrated service delivery framework, which will simplify and streamline human services eligibility and enrollment processes. The primary objectives for the simplification effort include significantly improved eligibility processing productivity resulting in reduced time for eligibility determination and enrollment, increased customer service for applicants and recipients of services, increased program integrity, and greater administrative flexibility.

(d) ~~The commissioner, along with a county representative appointed by the Association of Minnesota Counties, shall report specific implementation progress to the legislature annually beginning May 15, 2012.~~

~~(e)~~ The commissioner shall work with the Minnesota Association of County Social Service Administrators and the Office of Enterprise Technology to develop collaborative task forces, as necessary, to support implementation of the service delivery components under this paragraph. The commissioner must evaluate, develop, and include as part of the integrated eligibility and enrollment service delivery framework, the following minimum components:

(1) screening tools for applicants to determine potential eligibility as part of an online application process;

(2) the capacity to use databases to electronically verify application and renewal data as required by law;

(3) online accounts accessible by applicants and enrollees;

(4) an interactive voice response system, available statewide, that provides case information for applicants, enrollees, and authorized third parties;

(5) an electronic document management system that provides electronic transfer of all documents required for eligibility and enrollment processes; and

(6) a centralized customer contact center that applicants, enrollees, and authorized third parties can use statewide to receive program information, application assistance, and case information, report changes, make cost-sharing payments, and conduct other eligibility and enrollment transactions.

~~(f)~~ (e) Subject to a legislative appropriation, the commissioner of human services shall issue a request for proposal for the appropriate phase of an integrated service delivery system for health care programs, food support, cash assistance, and child care.

Sec. 9. **RULEMAKING; REDUNDANT PROVISION REGARDING TRANSITION LENSES.**

The commissioner of human services shall amend Minnesota Rules, part 9505.0277, subpart 3, to remove transition lenses from the list of eyeglass services not eligible for payment under the medical assistance program. The commissioner may use the good cause exemption in Minnesota Statutes, section 14.388, subdivision 1, clause (4), to adopt rules under this section. Minnesota Statutes, section 14.386, does not apply except as provided in Minnesota Statutes, section 14.388.

Sec. 10. **FEDERAL APPROVAL.**

By October 1, 2015, the commissioner of human services shall seek federal authority to operate the program in Minnesota Statutes, section 256B.78, under the state Medicaid plan, in accordance with United States Code, title 42, section 1396a(a)(10)(A)(ii)(XXI).

To be eligible, an individual must have family income at or below 200 percent of the federal poverty guidelines, except that for an individual under age 21, only the income of the individual must be considered in determining eligibility. Services under this program must be available on a presumptive eligibility basis.

Sec. 11. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall remove cross-references to the sections and parts repealed in section 12, paragraphs (a) and (b), wherever they appear in Minnesota Rules and shall make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2012, section 256.01, subdivision 32, is repealed.

(b) Minnesota Rules, parts 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; 9500.1456; and 9525.1580, are repealed.

(c) Minnesota Rules, parts 9505.5300; 9505.5305; 9505.5310; 9505.5315; and 9505.5325, are repealed contingent upon federal approval of the state Medicaid plan amendment under section 10. The commissioner of human services shall notify the revisor of statutes when this occurs.

APPENDIX
Article locations in H2402-1

**144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL DISORDERS.**

Subd. 6. **Standard retention period for samples and test results.** The standard retention period for blood samples with a negative test result is up to 71 days from the date of receipt of the sample. The standard retention period for blood samples with a positive test result is up to 24 months from the date of receipt of the sample. The standard retention period for all test results is up to 24 months from the last date of reporting. Blood samples with a negative test result will be destroyed within one week of the 71-day retention period. Blood samples with a positive test result will be destroyed within one week of the 24-month retention period. All test results will be destroyed within one month of the 24-month retention period. During the standard retention period, the Department of Health may use blood samples and test results for newborn screening program operations in accordance with subdivision 5.

**145A.02 DEFINITIONS.**

Subd. 2. **Board of health.** "Board of health" or "board" means an administrative authority established under section 145A.03 or 145A.07.

**145A.03 ESTABLISHMENT AND ORGANIZATION.**

Subd. 3. **Withdrawal from joint powers board of health.** A county or city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

Subd. 6. **Duplicate licensing.** A local board of health must work with the commissioner of agriculture to eliminate duplicate licensing and inspection of grocery and convenience stores by no later than March 1, 1992.

**145A.09 PURPOSE; FORMATION; ELIGIBILITY; WITHDRAWAL.**

Subdivision 1. **General purpose.** The purpose of sections 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Subd. 2. **Community health board; eligibility.** A board of health that meets the requirements of sections 145A.09 to 145A.131 is a community health board and is eligible for a local public health grant under section 145A.131.

Subd. 3. **Population requirement.** A board of health must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties to be eligible to form a community health board.

Subd. 4. **Cities.** A city that meets the requirements of sections 145A.09 to 145A.131 is eligible for a local public health grant under section 145A.131.

Subd. 5. **Human services board.** A county board or a joint powers board of health that establishes a community health board and has or establishes an operational human services board under chapter 402 must assign the powers and duties of a community health board to the human services board.

Subd. 7. **Withdrawal.** (a) A county or city that has established or joined a community health board may withdraw from the local public health grant program authorized by sections 145A.09 to 145A.131 by resolution of its governing body in accordance with section 145A.03, subdivision 3, and this subdivision.

(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

(c) The withdrawal of a county or city from a community health board does not affect the eligibility for the local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(d) The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

**145A.10 POWERS AND DUTIES OF COMMUNITY HEALTH BOARDS.**

Subdivision 1. **General.** A community health board has the powers and duties of a board of health prescribed in sections 145A.03, 145A.04, 145A.07, and 145A.08, as well as the general responsibility for development and maintenance of an integrated system of community health services as prescribed in sections 145A.09 to 145A.131.

Subd. 2. **Preemption.** (a) Not later than 365 days after the formation of a community health board, any other board of health within the community health service area for which the plan has been prepared must cease operation, except as authorized in a joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07, subdivision 2, or as otherwise allowed by this subdivision.

(b) This subdivision does not preempt or otherwise change the powers and duties of any city or county eligible for a local public health grant under section 145A.09.

(c) This subdivision does not preempt the authority to operate a community health services program of any city of the first or second class operating an existing program of community health services located within a county with a population of 300,000 or more persons until the city council takes action to allow the county to preempt the city's powers and duties.

Subd. 3. **Medical consultant.** The community health board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 4. **Employees.** Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights. Failure to comply with this subdivision does not affect eligibility under section 145A.09.

Subd. 5a. **Duties.** (a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

(1) establish local public health priorities based on an assessment of community health needs and assets; and

(2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, within the limits of available funding.
In determining the mechanisms to address local public health priorities and achieve statewide outcomes, the community health board shall seek public input or consider the recommendations of the community health advisory committee and the following essential public health services:

(i) monitor health status to identify community health problems;

(ii) diagnose and investigate problems and health hazards in the community;

(iii) inform, educate, and empower people about health issues;

(iv) mobilize community partnerships to identify and solve health problems;

(v) develop policies and plans that support individual and community health efforts;

(vi) enforce laws and regulations that protect health and ensure safety;

(vii) link people to needed personal health care services;

(viii) ensure a competent public health and personal health care workforce;

(ix) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and

(x) research for new insights and innovative solutions to health problems.

(b) By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant under section 145A.131 shall notify the commissioner in writing of the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, that the board will address and the local priorities established under paragraph (a) that the board will address.

(c) Each community health board receiving a local public health grant under section 145A.131 must submit an annual report to the commissioner documenting progress toward the achievement of statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, and the local public health priorities established under paragraph (a), using reporting standards and procedures established by the commissioner and in compliance with all applicable federal requirements. If a community health board has identified additional local priorities for use of the local public health grant since the last notification of outcomes and priorities under paragraph

(b), the community health board shall notify the commissioner of the additional local public health priorities in the annual report.

Subd. 7. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 9. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 10. **State and local advisory committees.** (a) A State Community Health Advisory Committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties. Notwithstanding section 15.059, the State Community Health Advisory Committee does not expire.

(b) The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 5a.

**145A.12 POWERS AND DUTIES OF COMMISSIONER.**

Subdivision 1. **Administrative and program support.** The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

(1) informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and

(2) administrative and program guidelines and standards, developed with the advice of the State Community Health Advisory Committee.

Subd. 2. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Subd. 7. **Statewide outcomes.** (a) The commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

(b) At least one statewide outcome must be established in each of the following public health areas:

(1) preventing diseases;

(2) protecting against environmental hazards;

(3) preventing injuries;

(4) promoting healthy behavior;

(5) responding to disasters; and

(6) ensuring access to health services.

(c) The commissioner shall use Minnesota's public health goals established under section 62J.212 and the essential public health services under section 145A.10, subdivision 5a, as a basis for the development of statewide outcomes.

(d) The statewide maternal and child health outcomes established under section 145.8821 shall be included as statewide outcomes under this section.

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), shall develop statewide outcomes for the local public health grant established under section 145A.131, based on state and local assessment data regarding the health of Minnesota residents, the essential public health services under section 145A.10, and current Minnesota public health goals established under section 62J.212.

**148.01 CHIROPRACTIC.**

Subd. 3. **Inclusions.** Chiropractic practice includes those noninvasive means of clinical, physical, and laboratory measures and analytical x-ray of the bones of the skeleton which are necessary to make a determination of the presence or absence of a chiropractic condition. The practice of chiropractic may include procedures which are used to prepare the patient for chiropractic adjustment or to complement the chiropractic adjustment. The procedures may not be used as independent therapies or separately from chiropractic adjustment. No device which utilizes heat or sound shall be used in the treatment of a chiropractic condition unless it has been approved by the Federal Communications Commission. No device shall be used above the neck of the patient. Any chiropractor who utilizes procedures in violation of this subdivision shall be guilty of unprofessional conduct and subject to disciplinary procedures according to section 148.10.

**148.6440 PHYSICAL AGENT MODALITIES.**

Subdivision 1. **General considerations.** (a) Occupational therapy practitioners who intend to use superficial physical agent modalities must comply with the requirements in subdivision 3. Occupational therapy practitioners who intend to use electrotherapy must comply with the requirements in subdivision 4. Occupational 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 licensed health care professional acting within the licensed health care professional's scope of practice.

(c) Prior to any use of any physical agent modality, 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) 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 therapy practitioner must provide to the commissioner documentation verifying that the occupational 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 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 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 licensed occupational therapist practitioner 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 therapy practitioner may use superficial physical agent modalities if the occupational 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 therapy practitioner may use electrotherapy if the occupational 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 therapy practitioner may use an ultrasound device if the occupational 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 therapy practitioners shall be advised of the status of their request for approval within 30 days. Occupational 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 therapy practitioner. If denied, the reason for denial shall be provided.

(d) 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, 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 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 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.

**148.7808 REGISTRATION; REQUIREMENTS.**

Subd. 2. **Registration by equivalency.** The board may register by equivalency an applicant who:

(1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12); and

(2) provides evidence satisfactory to the board of current certification by the National Athletic Trainers Association Board of Certification.

Applicants who were certified by the National Athletic Trainers Association through the "grandfather" process prior to 1971 are exempt from completing subdivision 1, clauses (2) and (9).

**148.7813 DISCIPLINARY PROCESS.**

Subdivision 1. **Investigation of complaints.** Upon receipt of a complaint or other communication pursuant to section 214.13, subdivision 6, that alleges or implies a violation of sections 148.7801 to 148.7815 by an applicant or registered athletic trainer, the board shall follow the procedures in section 214.10.

Subd. 2. **Grounds for disciplinary action.** The board may impose disciplinary action as described in subdivision 3 against an athletic trainer whom the board, after a hearing under the contested case provisions of chapter 14, determines:

(1) has knowingly made a false statement on a form required by the board for registration or registration renewal;

(2) has provided athletic training services in a manner that falls below the standard of care of the profession;

(3) has violated sections 148.7801 to 148.7815 or the rules adopted under these sections;

(4) is or has been afflicted with any physical, mental, emotional, or other disability, or addiction that, in the opinion of the board, adversely affects the person's ability to practice athletic training;

(5) has failed to cooperate with an investigation by the board;

(6) has been convicted or has pled guilty or nolo contendere to an offense that in the opinion of the board reasonably relates to the practice of athletic training or that bears on the athletic trainer's ability to practice athletic training;

(7) has aided and abetted in any manner a person in violating sections 148.7801 to 148.7815;

(8) has been disciplined by an agency or board of another state while in the practice of athletic training;

(9) has shown dishonest, unethical, or unprofessional conduct while in the practice of athletic training that is likely to deceive, defraud, or harm the public;

(10) has violated a state or federal law, rule, or regulation that in the opinion of the board reasonably relates to the practice of athletic training;

(11) has behaved in a sexual manner or what may reasonably be interpreted by a patient as sexual, or was verbally seductive or sexually demeaning to a patient;

(12) has misused alcohol, drugs, or controlled substances; or

(13) has violated an order issued by the board.

Subd. 3. **Disciplinary actions.** When grounds for disciplinary action exist under subdivision 2, the board may take one or more of the following actions:

(1) deny the right to practice;

(2) revoke the right to practice;

(3) suspend the right to practice;

(4) impose limitations on the practice of the athletic trainer;

(5) impose conditions on the practice of the athletic trainer;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the athletic trainer of any economic advantage gained by reason of the violation charged, or to discourage repeated violations;

(7) censure or reprimand the athletic trainer; or

(8) take any other action justified by the facts of the case.

Subd. 4. **Reinstatement.** An athletic trainer who has had registration revoked cannot apply for reinstatement. A suspended athletic trainer shall be reinstated upon evidence satisfactory to

the board of fulfillment of the terms of suspension. All requirements of section 148.7809 to renew registration, if applicable, must also be met before reinstatement.

**214.28 DIVERSION PROGRAM.**

A health-related licensing board may establish performance criteria and contract for a diversion program for regulated professionals who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition.

**214.36 BOARD PARTICIPATION.**

Participating boards may, by mutual agreement, implement the program upon enactment. Thereafter, health-related licensing boards desiring to enter into or discontinue an agreement to participate in the health professionals services program shall provide a written resolution indicating the board's intent to the designated board by January 1 preceding the start of a biennium.

**214.37 RULEMAKING.**

By July 1, 1996, the participating boards shall adopt joint rules relating to the provisions of sections 214.31 to 214.36 in consultation with the advisory committee and other appropriate individuals. The required rule writing does not prevent the implementation of sections 214.31 to 214.37 and Laws 1994, chapter 556, section 9, upon enactment.

**245D.071 SERVICE PLANNING AND DELIVERY; INTENSIVE SUPPORT SERVICES.**

Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder must develop, document, and implement an abuse prevention plan according to section 245A.65, subdivision 2.

**256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.**

Subd. 32. **Review and evaluation of ongoing studies.** The commissioner shall review all ongoing studies, reports, and program evaluations completed by the Department of Human Services for state fiscal years 2006 through 2010. For each item, the commissioner shall report the legislature's appropriation for that work, if any, and the actual reported cost of the completed work by the Department of Human Services. The commissioner shall make recommendations to the legislature about which studies, reports, and program evaluations required by law on an ongoing basis are duplicative, unnecessary, or obsolete. The commissioner shall repeat this review every five fiscal years.

**325H.06 NOTICE TO CONSUMER.**

The tanning facility owner or operator shall provide each consumer under the age of 18, before initial exposure at the facility, with a copy of the following warning, which must be signed, witnessed, and dated as indicated in the warning:

"WARNING STATEMENT

This statement must be read and signed by the consumer BEFORE first exposure to ultraviolet radiation for tanning purposes at the below signed facility.

DANGER - ULTRAVIOLET RADIATION WARNING

-Follow instructions.

-Avoid overexposure. As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. Repeated exposure may cause premature aging of the skin and skin cancer.

-Wear protective eyewear.

FAILURE TO USE PROTECTIVE EYEWEAR MAY RESULT IN SEVERE BURNS OR LONG-TERM INJURY TO THE EYES.

-Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult a physician before using sunlamp or tanning equipment if you are using medications or have a history of skin problems or believe yourself to be especially sensitive to sunlight.

I have read the above warning and understand what it means before undertaking any tanning equipment exposure.

.....

Signature of Operator of Tanning Facility or Equipment

.....

Signature of Consumer

.....

Print Name of Consumer

.....

Date

OR

The consumer is illiterate and/or visually impaired and I have read the warning statement aloud and in full to the consumer in the presence of the below signed witness.

.....

Signature of Operator of Tanning Facility or Equipment

.....

Witness

.....

Date"

**325H.08 CONSENT REQUIRED.**

Before allowing the initial exposure at a tanning facility of a person under the age of 16, the owner or operator shall witness the person's parent's or legal guardian's signing and dating of the warning statement required under section 325H.06.

***Laws 2011, First Special Session chapter 9, article 6, section 95 Subdivisions 1, 2, 3, 4,***

Sec. 95. MINNESOTA AUTISM SPECTRUM DISORDER TASK FORCE.

Subdivision 1. **Members.** (a) The Autism Spectrum Disorder Task Force is composed of 19 members, appointed as follows:

(1) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(2) two members of the house of representatives, one from the majority party, appointed by the speaker of the house, and one from the minority party, appointed by the minority leader;

(3) two members who are family members of individuals with autism spectrum disorder (ASD), one of whom shall be appointed by the majority leader of the senate, and one of whom shall be appointed by the speaker of the house;

(4) one member appointed by the Minnesota chapter of the American Academy of Pediatrics who is a developmental behavioral pediatrician;

(5) one member appointed by the Minnesota Academy of Family Physicians who is a family practice physician;

(6) one member appointed by the Minnesota Psychological Association who is a neuropsychologist;

(7) one member appointed by the majority leader of the senate who represents a minority autism community;

(8) one member representing the directors of public school student support services;

(9) one member appointed by the Minnesota Council of Health Plans;

(10) three members who represent autism advocacy groups, two of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the majority leader of the senate; and

(11) one member appointed by each of the respective commissioners of the following departments: education, employment and economic development, health, and human services.

(b) Appointments must be made by September 1, 2011. The senate member appointed by the majority leader of the senate shall convene the first meeting of the task force no later than October 1, 2011. The task force shall elect a chair from among members at the first meeting. The task force shall meet at least six times per year.

Subd. 2. **Duties.** (a) The task force shall develop an autism spectrum disorder statewide strategic plan that focuses on improving awareness, early diagnosis, and intervention and on ensuring delivery of treatment and services for individuals diagnosed with an autism spectrum disorder, including the coordination and accessibility of cost-effective treatments and services throughout the individual's lifetime.

(b) The task force shall coordinate with existing efforts relating to autism spectrum disorders at the Departments of Education, Employment and Economic Development, Health, and Human Services and at the University of Minnesota and other agencies and organizations as the task force deems appropriate.

Subd. 3. **Report.** The task force shall submit its strategic plan to the legislature by January 15, 2013. The task force shall continue to provide assistance with the implementation of the strategic plan, as approved by the legislature, and shall submit a progress report by January 15, 2014, and by January 15, 2015, on the status of implementation of the strategic plan, including any draft legislation necessary for implementation.

Subd. 4. **Expiration.** The task force expires June 30, 2015, unless extended by law.

**2500.0100 DEFINITIONS.**

Subp. 3. **Acupuncture.** "Acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment.

**2500.0100 DEFINITIONS.**

Subp. 4b. **Diagnosis.** "Diagnosis" means the physical, clinical, and laboratory examination of the patient, and the use of X-ray for diagnostic purposes within the scope of practice described in Minnesota Statutes, sections 148.01 to 148.10.

**2500.0100 DEFINITIONS.**

Subp. 9b. **Practice of chiropractic.** "Practice of chiropractic" includes the examination, diagnosis, prognosis, and treatment by chiropractic methods, or the rendering of opinions pertaining to those methods, for the purposes of determining a course of action in the best interests of the patient, such as a treatment plan or appropriate referral, or both. The methods may include those procedures preparatory or complementary to a chiropractic adjustment or other normal chiropractic regimen and rehabilitation of the patient as taught in accredited chiropractic schools or programs, pursuant to Minnesota Statutes, section 148.06.

**2500.4000 REHABILITATIVE TREATMENT.**

Rehabilitative therapy, within the context of the practice of chiropractic, may be done to prepare a patient for chiropractic adjustment or to complement the chiropractic adjustment, provided the treating chiropractor initiates the development and authorization of the rehabilitative therapy.

The administration of the rehabilitative therapy is the responsibility of the treating chiropractor.

The rehabilitative therapy must be rendered under the direct supervision of qualified staff.

**9500.1126 RECAPTURE OF DEPRECIATION.**

Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

**9500.1450 INTRODUCTION.**

Subp. 3. **Geographic area.** PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca and other geographical areas designated by the commissioner. If the geographic area is expanded beyond Dakota, Hennepin, and Itasca Counties, participating counties in the expanded area shall receive at least 180 days notice from the commissioner before implementation of PMAP and shall be governed by parts 9500.1450 to 9500.1464.

**9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.**

Subp. 3. **Exclusions during phase-in period.** The 65 percent of medical assistance eligible persons in Hennepin County who were not randomly selected to participate in the former medical assistance prepaid demonstration project because they served as a control group must participate in PMAP. Hennepin County may temporarily exclude individuals' participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Counties participating in the prepaid medical assistance program for the first time after June 30, 1991, may temporarily exclude PMAP consumers from participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

**9500.1456 IDENTIFICATION OF ENROLLEES.**

A MHP shall identify enrollees in a way convenient to its normal operational procedures.

**9505.5300 APPLICABILITY.**

Parts 9505.5300 to 9505.5325 govern the Minnesota Family Planning Program Section 1115 Demonstration Project. The demonstration project is a Medicaid waiver demonstration project approved by the Centers for Medicare and Medicaid Services to provide federally approved contraception management services to eligible low-income persons.

**9505.5305 DEFINITIONS.**

Subpart 1. **Scope.** The terms used in parts 9505.5300 to 9505.5325 have the meanings given them in this part.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written demonstration project application to the department for a determination of eligibility for the demonstration project.

Subp. 3. **Certified family planning services provider.** "Certified family planning services provider" means a family planning services provider that meets the requirements of part 9505.5315, subpart 1.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subp. 5. **Contraception management services.** "Contraception management services" means a scope of family planning services limited to initiating or obtaining an enrollee's contraceptive method and maintaining effective use of that method.

Subp. 6. **Countable income.** "Countable income" means the income, including deemed income, used to determine a person's eligibility for the demonstration project.

Subp. 7. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256B.02, subdivision 6.

Subp. 8. **Demonstration project.** "Demonstration project" means the Minnesota Family Planning Program Section 1115 Demonstration Project, Project Number 11-W-00183/5.

Subp. 9. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 10. **Enrollee.** "Enrollee" means a person enrolled in the demonstration project.

Subp. 11. **Family planning services provider.** "Family planning services provider" includes the providers listed in part 9505.0280, subpart 3, and clinical nurse specialists, laboratories, ambulatory surgical centers, federally qualified health centers, Indian Health Services, public health nursing clinics, and physician assistants who are authorized providers under part 9505.0195.

Subp. 12. **Family size.** "Family size" means the number of people used to determine a person's income standard. The family size includes the person and the following people who live with the person: the person's spouse, the biological and adoptive children of the person who are under age 21, and the biological and adoptive children of the person's spouse who are under age 21.

Subp. 13. **Minnesota health care program.** "Minnesota health care program" means medical assistance under Minnesota Statutes, chapter 256B, general assistance medical care under Minnesota Statutes, section 256D.03, and MinnesotaCare under Minnesota Statutes, chapter 256L.

Subp. 14. **Presumptive eligibility.** "Presumptive eligibility" means the temporary period of eligibility for the demonstration project that is determined at the point of service by a certified family planning services provider.

Subp. 15. **Qualified noncitizen eligible for medical assistance with federal financial participation.** "Qualified noncitizen eligible for medical assistance with federal financial participation" means a person that meets the requirements of Minnesota Statutes, section 256B.06, subdivision 4.

Subp. 16. **Resident.** "Resident" means a person who meets the requirements in part 9505.0030.

**9505.5310 DEMONSTRATION PROJECT ELIGIBILITY, APPLICATION, ENROLLMENT, AND DOCUMENTATION.**

Subpart 1. **General eligibility.** The eligibility and coverage requirements in this subpart apply to applicants and enrollees.

A. Except as provided in subpart 2, an applicant or enrollee must meet the following requirements to be eligible for the demonstration project:

(1) be a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation;

(2) be a Minnesota resident;

(3) be 15 years of age or older and under age 50;

(4) have countable income at or below 200 percent of the federal poverty guidelines for the family size. Countable income is determined according to the income rules applied in eligibility determinations for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, and United States Code, title 42, chapter 7, subchapter XIX, section 1396u-1, as follows:

(a) income includes all categories of earned and unearned income used in eligibility determinations for families and children under the medical assistance program;

(b) income does not include any categories of income that are excluded for purposes of determining eligibility for families and children in the medical assistance program;

(c) income methodologies, such as earned income deductions and disregards, used to determine eligibility for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, subdivisions 1a and 1c, do not apply to the determination of countable income; and

(d) income deeming requirements used to determine eligibility for families and children in the medical assistance program apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person;

(5) not be pregnant;

(6) not be enrolled in the Minnesota health care program or other health service program administered by the department; and

(7) not be an institutionalized individual as described under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009.

B. Participation in the demonstration project does not require the consent of anyone other than the applicant.

C. Asset requirements do not apply to applicants and enrollees.

D. Applicants and enrollees must report available third-party coverage and cooperate with the department in obtaining third-party payments. The department shall waive this requirement if the applicant or enrollee states that reporting third-party coverage could violate the applicant's or enrollee's privacy.

Subp. 2. **Presumptive eligibility.** Services covered under the demonstration project may be provided during a presumptive eligibility period.

A. A certified family planning services provider will screen a person for demonstration project eligibility using preliminary information provided by the person. A person who, based on the preliminary information, appears to meet the eligibility requirements in part 9505.5310, subpart 1, item A, subitems (2) to (6), is presumptively eligible for the demonstration project.

B. The presumptive eligibility period begins the first day of the month that a certified family planning services provider determines that a person is presumptively eligible. The presumptive eligibility period ends the last day of the month following the month that the certified family planning services provider determines that a person was presumptively eligible.

C. A person determined presumptively eligible must comply with part 9505.5310, subpart 1, item D.

D. A person may receive presumptive eligibility once during a 12-month period.

Subp. 3. **Enrollment.** An applicant must apply for the demonstration project using forms provided by the department.

A. The department or county agency must determine an applicant's eligibility for the demonstration project within 45 days of receipt of a completed application.

B. Except as provided in item C, eligibility begins the first day of the month of application. If a completed application form is submitted within 30 days of the request, the month of application includes the month the department or county agency receives a written request for the demonstration project consisting of at least the name of the applicant, a means to locate the applicant, and the signature of the applicant.

C. A person who is eligible under subparts 1 and 2 and files a demonstration project application during the presumptive eligibility period is eligible for ongoing coverage on the first day of the month following the month that presumptive eligibility ends.

Subp. 4. **Application and documentation.** The application and documentation requirements in this subpart apply to all applicants and enrollees.

A. An enrollee is eligible for the demonstration project for one year regardless of changes in income or family size. Eligibility will end prior to the annual renewal if the enrollee:

(1) dies;

(2) is no longer a Minnesota resident;

(3) voluntarily terminates eligibility;

(4) enrolls in the Minnesota health care program or other health service program administered by the department;

(5) reaches 50 years of age;

(6) becomes pregnant;

(7) becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009; or

(8) is no longer a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation.

B. Applicants and enrollees must document their income at application.

C. Enrollees must complete an annual application on forms provided by the department.

D. Applicants and enrollees must provide documentation of immigration status at application. The department or county agency will verify applicant and enrollee immigration status according to Minnesota Statutes, section 256.01, subdivision 18.

E. Applicants and enrollees must report a change in an eligibility factor to the department or county agency within ten days of learning about the change. Applicants and enrollees who fail to report a change that would have resulted in ineligibility for the demonstration project will be disenrolled from the demonstration project and will be ineligible for the demonstration project for a period of 12 months following the date of disenrollment. If the only unreported change is a pregnancy, applicants and enrollees will not be subject to the 12 months ineligibility period, but pregnant applicants and enrollees will be disenrolled from the demonstration project and may reapply for the demonstration project following the end of the pregnancy.

F. Applicants and enrollees must provide information, documents, and any releases requested by the department or county agency that are necessary to verify eligibility information. An applicant or enrollee who refuses to authorize verification of an eligibility factor, including a Social Security number, is not eligible for the demonstration project, except as provided in Code of Federal Regulations, title 42, section 435.910(h)(2).

G. Applicants must document citizenship as required by the federal Deficit Reduction Act of 2005, Public Law 109-71. Persons screened for presumptive eligibility under subpart 2 are not required to document citizenship.

H. An applicant may withdraw an application according to the provisions of part 9505.0090, subpart 4.

Subp. 5. **Enrollment.** To be considered for Minnesota health care program eligibility, an enrollee must complete the department's health care application. Applicants and enrollees shall not use a demonstration project application form to apply for the Minnesota health care program. People who complete the department's health care application and are determined ineligible for the Minnesota health care program, either at application or during enrollment, may authorize a demonstration project eligibility determination using the information provided in the department's health care application and updated at required intervals.

Subp. 6. **Confidentiality.** Private data about persons screened for eligibility, applicants, and enrollees must be disclosed according to the provisions of the following statutes and rules:

A. part 1205.0500 and Minnesota Statutes, chapter 13;

B. Minnesota Statutes, sections 144.291 to 144.298;

C. Minnesota Statutes, section 144.343;

D. Code of Federal Regulations, title 45, parts 160, 162, and 164; and

E. other applicable state and federal laws, statutes, rules, and regulations affecting the collection, storage, use, and dissemination of protected, private, and confidential health and other information.

Subp. 7. **Notices.** Applicants and enrollees may arrange to receive notices in a manner other than having notices mailed to the applicant's or enrollee's home address.

**9505.5315 PROVIDERS OF FAMILY PLANNING SERVICES.**

Subpart 1. **Certified family planning services provider requirements.** To become a certified family planning services provider, a family planning services provider must:

A. sign the business associate agreement;

B. complete required training;

C. provide information about presumptive eligibility to interested persons;

D. help interested persons complete demonstration project applications and forms;

E. use the department's eligibility verification system to verify a person screened for demonstration project eligibility does not receive Minnesota health care program coverage;

F. determine presumptive eligibility;

G. give required notices to a person screened for eligibility;

H. promptly forward completed applications and forms to the department; and

I. cooperate with department application tracking and program evaluation activities.

Subp. 2. **Covered services.** The demonstration project covers contraception management services and certain additional medical diagnosis or treatment services that are provided within the context of a visit for contraception management services. All services covered by the demonstration project are listed in Attachment B of the Centers for Medicare and Medicaid Services Special Terms and Conditions for the Minnesota Family Planning Program Section 1115 Demonstration, Project Number 11-W-00183/5 and its amendments, which are incorporated by reference. This document can be found at the Minnesota Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. Attachment B is subject to frequent change.

Subp. 3. **Payment for services.** Family planning services providers are paid for covered services as follows:

A. No cost-sharing requirements apply to services provided under the demonstration project.

B. Payments will be made on a fee-for-service basis to providers for services provided under the demonstration project.

C. All covered services provided during the presumptive eligibility period according to part 9505.5310, subpart 2, will be reimbursed.

D. The demonstration project is the payer of last resort. The demonstration project will not cover drugs that are covered under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A).

E. Parts 9505.2160 to 9505.2245, regarding surveillance and integrity review, apply to services provided under parts 9505.5300 to 9505.5325.

**9505.5325 APPEALS.**

Subpart 1. **Notice.** The commissioner must follow the notification procedures in part 9505.0125 if the commissioner denies, suspends, reduces, or terminates eligibility or covered health services, except as provided in subpart 3.

Subp. 2. **Appeal process.** A person aggrieved by a determination or action of the commissioner under parts 9505.5300 to 9505.5325 may appeal the department's or county agency's determination or action according to Minnesota Statutes, section 256.045, except as provided in subpart 3.

Subp. 3. **Denial of presumptive eligibility.** There is no right of appeal for a denial of presumptive eligibility.

**9525.1580 CONTROL AND LOCATION OF SERVICES.**

Subpart 1. **Definitions.** The terms used in subparts 2 and 3 have the meanings given them in this subpart.

A. "Related legal entities" means entities that share any governing board members or an executive director or are owned or partially owned by the same individual or individuals, or by related individuals.

B. "Related individuals" means individuals whose relationship to each other by blood, marriage, or adoption is not more remote than first cousin.

Subp. 2. **Control of services.** Training and habilitation services licensed under Minnesota Statutes, chapter 245B and licensed residential services must not be provided to the same person by related legal entities. This requirement does not apply:

A. to residential and day habilitation services directly administered by a county board or by the commissioner at a regional center;

B. to residential and day habilitation services offered by a training and habilitation services provider licensed before April 15, 1983; or

C. to services provided to a person who resides at home with the person's family or foster family and who is receiving a combination of day habilitation and residential based habilitation services under parts 9525.1800 to 9525.1930.

Subp. 3. **Location of services.** Training and habilitation services must be provided away from the residence of the person receiving services in communities where the person lives and works.