

**CHAPTER 291--H.F.No. 2402**

*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 occupations, Department of Health, public health, continuing care, public assistance programs, and health care; establishing reporting requirements and grounds for disciplinary action for health professionals; making changes to the medical assistance program; modifying provisions governing child care and juvenile safety and placement; regulating the sale and use of tobacco-related and electronic delivery devices; modifying requirements for local boards of health; making changes to provisions governing the Board of Pharmacy; modifying home and community-based services standards; revising the Minnesota family investment program; establishing and modifying task forces and advisory councils; making changes to grant programs; modifying certain penalty fees; requiring studies and reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2012, sections 13.46, subdivision 2; 62J.497, subdivision 5; 119B.02, subdivision 2; 119B.09, subdivisions 6, 13; 144.414, subdivisions 2, 3, by adding a subdivision; 144.4165; 144D.065; 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; 146A.01, subdivision 6; 148.01, subdivisions 1, 2, by adding a subdivision; 148.105, subdivision 1; 148.261, subdivision 4, by adding a subdivision; 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; 148.996, 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, subdivisions 3, 8, 16; 150A.10; 151.01; 151.06; 151.211; 151.26; 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; 214.09, subdivision 3; 214.103, subdivisions 2, 3; 214.12, by adding a subdivision; 214.29; 214.31; 214.32, by adding a subdivision; 214.33, subdivision 3, by adding a subdivision; 245A.02, subdivision 19; 245A.03, subdivision 6a; 245C.04, by adding a subdivision; 253B.092, subdivision 2; 254B.01, by adding a subdivision; 254B.05, subdivision 5; 256B.0654, subdivision 1; 256B.0659, subdivisions 11, 28; 256B.493, subdivision 1; 256B.5016, subdivision 1; 256B.69, subdivision 16, by adding a subdivision; 256D.01, subdivision 1e; 256D.05, by adding a subdivision; 256D.405, subdivision 1; 256E.30, by adding a subdivision; 256G.02, subdivision 6; 256I.03, subdivision 3; 256I.04, subdivisions 1a, 2a; 256J.09, subdivision 3; 256J.20, subdivision 3; 256J.30, subdivisions 4, 12; 256J.32, subdivisions 6, 8; 256J.38, subdivision 6; 256J.49, subdivision 13; 256J.521, subdivisions 1, 2; 256J.53, subdivisions 2, 5; 256J.626, subdivisions 5, 8; 256J.67; 256J.68, subdivisions 1, 2, 4, 7, 8; 256J.751, subdivision 2; 256K.26, subdivision 4; 260C.157, subdivision 3; 260C.212, subdivision 2; 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; 626.5561, subdivision 1; Minnesota Statutes 2013 Supplement, sections 144.1225, subdivision 2; 144.493, subdivisions 1, 2; 144.494, subdivision 2; 144A.474, subdivisions 8, 12; 144A.475, subdivision 3, by adding subdivisions; 144A.4799, subdivision 3; 145A.06, subdivision 7; 146A.11, subdi-*

*vision 1; 151.252, by adding a subdivision; 152.02, subdivision 2; 245A.1435; 245A.50, subdivision 5; 245D.071, subdivisions 1, 4; 245D.09, subdivisions 4, 4a, 5; 245D.33; 254A.035, subdivision 2; 254A.04; 256B.04, subdivision 21; 256B.0625, subdivision 9; 256B.0659, subdivision 21; 256B.0922, subdivision 1; 256B.4912, subdivision 10; 256B.492; 256B.85, subdivision 12; 256D.44, subdivision 5; 256J.21, subdivision 2; 256J.24, subdivision 3; 256J.621, subdivision 1; 256J.626, subdivision 6; 260.835, subdivision 2; 364.09; 626.556, subdivision 7; 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; 2014 H.F. No. 2950, article 1, section 12, if enacted; proposing coding for new law in Minnesota Statutes, chapters 144; 144D; 145; 146A; 150A; 151; 214; 245A; 260D; 325H; 403; 461; repealing Minnesota Statutes 2012, sections 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; 256.01, subdivision 32; 325H.06; 325H.08; Minnesota Statutes 2013 Supplement, section 148.6440; 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 FAMILIES

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 2013 Supplement, section 245A.1435, is amended to read:

### **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH IN LICENSED PROGRAMS.**

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's physician directing an alternative sleeping position for the infant. The physician directive must be on a form approved by the commissioner and must remain on file at the licensed location. An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

(b) The license holder must place the infant in a crib directly on a firm mattress with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place anything in the crib with the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title 16, part 1511. The requirements of this section apply to license holders serving infants younger than one year of age. Licensed child care providers must meet the crib requirements under section 245A.146. A correction order shall not be issued under this paragraph unless there is evidence that a violation occurred when an infant was present in the license holder's care.

(c) If an infant falls asleep before being placed in a crib, the license holder must move the infant to a crib as soon as practicable, and must keep the infant within sight of the license holder until the infant is placed in a crib. When an infant falls asleep while being held, the license holder must consider the supervision needs of other children in care when determining how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant must not be in a position where the airway may be blocked or with anything covering the infant's face.

(d) Placing a swaddled infant down to sleep in a licensed setting is not recommended for an infant of any age and is prohibited for any infant who has begun to roll over independently. However, with the written consent of a parent or guardian according to this paragraph, a license holder may place the infant who has not yet begun to roll over on its own down to sleep in a one-piece sleeper equipped with an attached system that fastens securely only across the upper torso, with no constriction of the hips or legs, to create a swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant on a form provided by the commissioner and prepared in partnership with the Minnesota Sudden Infant Death Center.

### **Sec. 3. [245A.1511] CONTRACTORS SERVING MULTIPLE FAMILY CHILD CARE LICENSE HOLDERS.**

Contractors who serve multiple family child care holders may request that the county agency maintain a record of:

(1) the contractor's background study results as required in section 245C.04, subdivision 7, to verify that the contractor does not have a disqualification or a disqualification that has not been set aside, and is eligible to provide direct contact services in a licensed program; and

(2) the contractor's compliance with training requirements.

Sec. 4. Minnesota Statutes 2013 Supplement, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are in-

structed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length and must be completed in person at least once every two years. On the years when the license holder is not receiving the in-person training on sudden unexpected infant death reduction, the license holder must receive sudden unexpected infant death reduction training through a video of no more than one hour in length developed or approved by the commissioner, at a minimum, the training must address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Abusive head trauma training required under this subdivision must be at least one-half hour in length and must be completed at least once every year, at a minimum, the training must address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development. Sudden unexpected infant death reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

(e) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. On the years when the license holder is not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the license holder must receive sudden unexpected infant death reduction training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

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

Sec. 5. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision to read:

**Subd. 7. Current or prospective contractors serving multiple family child care license holders.** Current or prospective contractors who are required to have a background study under section 245C.03, subdivision 1, who provide services for multiple family child care license holders in a single county, and will have direct contact with children served in the family child care setting are required to have only one background study which is transferable to all family child care programs in that county if:

(1) the county agency maintains a record of the contractor's background study results which verify the contractor is approved to have direct contact with children receiving services;

(2) the license holder contacts the county agency and obtains notice that the current or prospective contractor is in compliance with background study requirements and approved to have direct contact; and

(3) the contractor's background study is repeated every two years.

Sec. 6. Minnesota Statutes 2012, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's relationship to current caretakers, parents, siblings, and relatives; and

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study is required under section 245C.08 before the approval of a foster placement in a related or unrelated home; and (2) a completed review of the written home study required under section

260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

Sec. 7. 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. 8. 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. 9. 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 en-

vironment 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. 10. 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 commissioner 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. 11. 2014 H.F. No. 2950, article 1, section 12, if enacted, is amended to read:

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2012, sections 119A.04, subdivision 1; 119B.09, subdivision 2; 119B.23; 119B.231; 119B.232; 256.01, subdivisions 3, 14, and 14a; 256.9792; 256D.02, subdivision 19; 256D.05, subdivision 4; 256D.46; 256I.05, subdivisions 1b and 5; 256I.07; 256K.35; 259.85, subdivisions 2, 3, 4, and 5; 518A.53, subdivision 7; ~~518A.74~~; and 626.5593, are repealed.

(b) Minnesota Statutes 2012, section 256J.24, subdivision 10, is repealed effective October 1, 2014.

(c) Minnesota Statutes 2013 Supplement, section 259.85, subdivision 1, is repealed.

Sec. 12. **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.

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

**ARTICLE 2****PROVISION OF HEALTH SERVICES****Section 1. [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. 2. [151.71] MAXIMUM ALLOWABLE COST PRICING.**

Subdivision 1. **Definition.** (a) For purposes of this section, the following definitions apply.

(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 is received; 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 an 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. 3. 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.

~~(e)~~ (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; and
- (10) an association of medical examiners and coroners.

(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; and

(4) criteria for the unsolicited provision of prescription monitoring data by the board to prescribers and dispensers.

(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, part 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 (6) and (7), 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 24 months must be de-identified.

(e) The board shall not retain data reported under subdivision 4 for a period longer than four years from the date the data was received.

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) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care if the patient has consented to access to the submitted data;

~~(3)~~ (4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

~~(4)~~ (5) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee;

~~(5)~~ (6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

~~(6)~~ (7) 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 requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

~~(7)~~ (8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

~~(8)~~ (9) personnel of the ~~medical assistance program~~ Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care physician provider, a single outpatient pharmacy, or a single hospital; and

~~(9)~~ (10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (h); and

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

For purposes of clause ~~(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), (3), (6), (7), (9), and (10) 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.

(g) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph. The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services policy and finance on the interstate prescription monitoring program by January 5, 2016.

(h) 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.

(i) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met. The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services policy and finance on the criteria established under this paragraph and the review process by January 5, 2016. This paragraph expires August 1, 2016.

**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. 4. STUDY REQUIRED; PRESCRIPTION MONITORING PROGRAM DATABASE.

(a) The Board of Pharmacy, in collaboration with the Prescription Monitoring Program Advisory Task Force, shall study the program database and report to the chairs and ranking minority members of the senate health and human services policy and finance division and the house of representatives health and human services policy and finance committees by December 15, 2014, with recommendations on: (1) requiring the use of the prescription monitoring 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) allowing for the use of the prescription monitoring program database to identify potentially inappropriate prescribing of controlled substances; and (3) encouraging access to appropriate treatment for prescription drug abuse through the prescription monitoring program.

(b) The Board of Pharmacy, in collaboration with the prescription monitoring program advisory task force, shall conduct a study designed to assess the impact of the prescription monitoring program on the level of doctor-shopping activities and report to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction on health and human services policy and finance by December 15, 2016.

### 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, or community residential settings licensed under chapter 245D, 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 or community residential setting 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 section may be incorporated into the 30 hours of staff orientation required under section 245D.09, subdivision 4.

~~(e)~~ (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 or community residential setting 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 or community residential

setting 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.~~

(e) 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 prior to admission to a treatment facility, but lacks the capacity to consent to the administration of that neuroleptic medication; 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. 4a. 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 146A.01, subdivision 6, is amended to read:

Subd. 6. **Unlicensed complementary and alternative health care practitioner.** (a) "Unlicensed complementary and alternative health care practitioner" means a person who:

(1) either:

(i) is not licensed or registered by a health-related licensing board or the commissioner of health; or

(ii) is licensed or registered by the commissioner of health or a health-related licensing board other than the Board of Medical Practice, the Board of Dentistry, the Board of Chiropractic Examiners, or the Board of Podiatric Medicine, but does not hold oneself out to the public as being licensed or registered by the commissioner or a health-related licensing board when engaging in complementary and alternative health care;

(2) has not had a license or registration issued by a health-related licensing board or the commissioner of health revoked or has not been disciplined in any manner at any time in the past, unless the right to engage in complementary and alternative health care practices has been established by order of the commissioner of health;

(3) is engaging in complementary and alternative health care practices; and

(4) is providing complementary and alternative health care services for remuneration or is holding oneself out to the public as a practitioner of complementary and alternative health care practices.

~~(b) A health care practitioner licensed or registered by the commissioner or a health-related licensing board, who engages in complementary and alternative health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the complementary and alternative health care practices.~~

**Sec. 2. [146A.065] COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTICES BY LICENSED OR REGISTERED HEALTH CARE PRACTITIONERS.**

(a) A health care practitioner licensed or registered by the commissioner or a health-related licensing board, who engages in complementary and alternative health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the complementary and alternative health care practices.

(b) A health care practitioner licensed or registered by the commissioner or a health-related licensing board shall not be subject to disciplinary action solely on the basis of utilizing complementary and alternative health care practices as defined in section 146A.01, subdivision 4, paragraph (a), as a component of a patient's treatment, or for referring a patient to a complementary and alternative health care practitioner as defined in section 146A.01, subdivision 6.

(c) A health care practitioner licensed or registered by the commissioner or a health-related licensing board who utilizes complementary and alternative health care practices must provide patients receiving these services with a written copy of the complementary and alternative health care client bill of rights pursuant to section 146A.11.

(d) Nothing in this section shall be construed to prohibit or restrict the commissioner or a health-related licensing board from imposing disciplinary action for conduct that violates provisions of the applicable licensed or registered health care practitioner's practice act.

Sec. 3. Minnesota Statutes 2013 Supplement, section 146A.11, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) All unlicensed complementary and alternative health care practitioners shall provide to each complementary and alternative health care client prior to providing treatment a written copy of the complementary and alternative health care client bill of rights. A copy must also be posted in a prominent location in the office of the unlicensed complementary and alternative health care practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication disabilities and those who do not read or speak English. The complementary and alternative health care client bill of rights shall include the following:

(1) the name, complementary and alternative health care title, business address, and telephone number of the unlicensed complementary and alternative health care practitioner;

(2) the degrees, training, experience, or other qualifications of the practitioner regarding the complementary and alternative health care being provided, followed by the following statement in bold print:

**"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.**

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.";

(3) the name, business address, and telephone number of the practitioner's supervisor, if any;

(4) notice that a complementary and alternative health care client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints;

(5) the name, address, and telephone number of the office of unlicensed complementary and alternative health care practice and notice that a client may file complaints with the office;

(6) the practitioner's fees per unit of service, the practitioner's method of billing for such fees, the names of any insurance companies that have agreed to reimburse the practitioner, or health maintenance organizations with whom the practitioner contracts to provide service, whether the practitioner accepts Medicare, medical assistance, or general assistance medical care, and whether the practitioner is willing to accept partial payment, or to waive payment, and in what circumstances;

(7) a statement that the client has a right to reasonable notice of changes in services or charges;

(8) a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to clients;

(9) notice that the client has a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided;

(10) a statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner;

(11) a statement that client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law;

(12) a statement of the client's right to be allowed access to records and written information from records in accordance with sections 144.291 to 144.298;

(13) a statement that other services may be available in the community, including where information concerning services is available;

(14) a statement that the client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(15) a statement that the client has a right to coordinated transfer when there will be a change in the provider of services;

(16) a statement that the client may refuse services or treatment, unless otherwise provided by law; and

(17) a statement that the client may assert the client's rights without retaliation.

(b) This section does not apply to an unlicensed complementary and alternative health care practitioner who is employed by or is a volunteer in a hospital or hospice who provides services to a client in a hospital or under an appropriate hospice plan of care. Patients receiving complementary and alternative health care services in an inpatient hospital or under an appropriate hospice plan of care shall have and be made aware of the right to file a complaint with the hospital or hospice provider through which the practitioner is employed or registered as a volunteer.

(c) This section does not apply to a health care practitioner licensed or registered by the commissioner of health or a health-related licensing board who utilizes complementary and alternative health care practices within the scope of practice of the health care practitioner's professional license.

Sec. 4. 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. 5. 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. 6. 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, and 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. 7. 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. 8. Minnesota Statutes 2012, section 148.261, is amended by adding a subdivision to read:

**Subd. 1a. Conviction of a felony-level criminal sexual offense.** (a) Except as provided in paragraph (e), the board may not grant or renew a license to practice nursing to any person who has been convicted on or after August 1, 2014, of any of the provisions of sections 609.342, subdivision 1, 609.343, subdivision 1, 609.344, subdivision 1, paragraphs (c) to (o), or 609.345, subdivision 1, paragraphs (c) to (o), or a similar statute in another jurisdiction.

(b) A license to practice nursing is automatically revoked if the licensee is convicted of an offense listed in paragraph (a).

(c) A license to practice nursing that has been denied or revoked under this subdivision is not subject to chapter 364.

(d) For purposes of this subdivision, "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) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become licensed provided that the criteria:

- (1) utilize a rebuttable presumption that the applicant is not suitable for licensing;
- (2) provide a standard for overcoming the presumption; and
- (3) require that a minimum of ten years has elapsed since the applicant's sentence was discharged.

The board 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.

Sec. 9. Minnesota Statutes 2012, section 148.261, subdivision 4, is amended to read:

**Subd. 4. Evidence.** In disciplinary actions alleging a violation of subdivision 1, clause (3) or (4), or subdivision 1a, 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 violation concerned.

Sec. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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. 21. 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. 22. 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. 23. 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), Birthworks, the Childbirth and Postpartum Professional Association (CAPP), Childbirth International, ~~or~~ the International Center for Traditional Childbearing, or Commonsense Childbirth, Inc.

Sec. 24. Minnesota Statutes 2012, section 148.996, subdivision 2, is amended to read:

Subd. 2. **Qualifications.** The commissioner shall include on the registry any individual who:

(1) submits an application on a form provided by the commissioner. The form must include the applicant's name, address, and contact information;

(2) maintains a current certification from one of the organizations listed in section ~~146B.01, subdivision 2~~ 148.995, subdivision 2; and

(3) pays the fees required under section 148.997.

Sec. 25. 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. 26. 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. 27. 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. 28. 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. 29. 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. 30. 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. 31. 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. 32. 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. 33. 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. 34. 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. 35. 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. 36. 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. 37. Minnesota Statutes 2012, section 150A.091, subdivision 3, is amended to read:

Subd. 3. **Initial license or permit fees.** Along with the application fee, each of the following applicants shall submit a separate ~~prorated~~ initial license or permit fee. The ~~prorated~~ initial fee shall be established by the board ~~based on the number of months of the applicant's initial term as described in Minnesota Rules, part 3100.1700, subpart 1a,~~ not to exceed the following monthly nonrefundable fee amounts:

(1) dentist or full faculty dentist, ~~\$14 times the number of months of the initial term~~ \$168;

(2) dental therapist, ~~\$10 times the number of months of the initial term~~ \$120;

(3) dental hygienist, ~~\$5 times the number of months of the initial term~~ \$60;

(4) licensed dental assistant, ~~\$3 times the number of months of the initial term~~ \$36; and

(5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, ~~\$1 times the number of months of the initial term~~ \$12.

Sec. 38. Minnesota Statutes 2012, section 150A.091, subdivision 8, is amended to read:

Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request for issuance of a duplicate of the original license, or of an annual or biennial renewal certificate for a license or permit, a fee in the following amounts:

(1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant license, \$35; and

(2) annual or biennial renewal certificates, ~~\$10~~; and

(3) wallet-sized license and renewal certificate, \$15.

Sec. 39. 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. 40. 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. 41. 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. 42. 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. 43. 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. 44. 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. 45. Minnesota Statutes 2012, section 153.16, is amended by adding a subdivision to read:

Subd. 5. **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. 46. **[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 begin no later than 30 days after issuance of the suspension order.

(d) If the board has not completed its investigation and issued a final order within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation.

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

Sec. 47. Minnesota Statutes 2012, section 214.09, subdivision 3, is amended to read:

Subd. 3. **Compensation.** ~~(a) Members of the boards may be compensated at the rate of \$55 a day spent on board activities, when authorized by the board, plus expenses in~~ Members of health-related licensing boards may be compensated at the rate of \$75 a day spent on board activities and members of nonhealth-related licensing boards may be compensated at the rate of \$55 a day spent on board activities when authorized by the board, plus expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred, may be reimbursed for those expenses upon board authorization.

(b) Members who are state employees or employees of the political subdivisions of the state must not receive the daily payment for activities that occur during working hours for which they are also compensated by the state or political subdivision. However, a state or political subdivision employee may receive the daily payment if the employee uses vacation time or compensatory time accumulated in accordance with a collective bargaining agreement or compensation plan for board activity. Members who are state employees or employees of the political subdivisions of the state may receive the expenses provided for in this subdivision unless the expenses are reimbursed by another source. Members who are state employees or employees of political subdivisions of the state may be reimbursed for child care expenses only for time spent on board activities that are outside their working hours.

(c) Each board must adopt internal standards prescribing what constitutes a day spent on board activities for purposes of making daily payments under this subdivision.

Sec. 48. 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. 49. 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. 50. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision to read:

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

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

Sec. 51. Minnesota Statutes 2012, section 214.29, is amended to read:

#### **214.29 PROGRAM REQUIRED.**

Notwithstanding section 214.28, 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, and sunsets July 1, 2015.

Sec. 52. 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 Notwithstanding section 214.36, 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, and sunsets July 1, 2015.

Sec. 53. Minnesota Statutes 2012, section 214.32, is amended by adding a subdivision to read:

Subd. 6. **Duties of a participating board.** Upon receiving a report from the program manager in accordance with section 214.33, subdivision 3, that a regulated person has been discharged from the program due to noncompliance based on allegations that the regulated person has engaged in conduct that might cause risk to the public, when the participating board has probable cause to believe continued practice by the regulated person presents an imminent risk of harm, the board shall temporarily suspend the regulated person's professional license until the completion of a disciplinary investigation. The board must complete the disciplinary investigation within 30 days of receipt of the report from the program. If the investigation is not completed by the board within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation.

Sec. 54. 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;
- (3) leaves or is discharged from 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) causes identifiable patient harm;
- (6) unlawfully substitutes or adulterates medications;
- (7) writes a prescription or causes a prescription to be dispensed in the name of a person, other than the prescriber, or veterinary patient for the personal use of the prescriber;
- (8) alters a prescription without the knowledge of the prescriber for the purpose of obtaining a drug for personal use;
- (9) unlawfully uses a controlled or mood-altering substance or uses alcohol while providing patient care or during the period of time in which the regulated person may be contacted to provide patient care or is otherwise on duty, if current use is the reason for participation in the program or the use occurs while the regulated person is participating in the program; or

~~The program manager shall report to the appropriate participating board a regulated person who (10) 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 August 1, 2014, and applies to violations that occur after the effective date.~~

Sec. 55. 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 regulated by a health-related licensing board, and a health care institution or other organization where the regulated person is engaged in providing services, must report to the appropriate licensing board that a regulated person has diverted narcotics or other controlled substances in violation of state or federal narcotics or controlled substance law if:

(1) the employer, health care institution, or organization making the report has knowledge of the diversion; and

(2) the regulated person has diverted narcotics or other controlled substances from the reporting employer, health care institution, or organization, or at the reporting institution or organization.

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

(1) the regulated person is self-employed;

(2) the knowledge was obtained in the course of a professional-patient relationship and the regulated person is the patient; or

(3) knowledge of the diversion first becomes known to the employer, health care institution, or other organization, either from (i) an individual who is serving as a work site monitor approved by the health professional services program for the regulated person who has self-reported to the health professional services program, and who has returned to work pursuant to a health professional services program participation agreement and monitoring plan; or (ii) the 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.

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

Sec. 56. **[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. 57. Minnesota Statutes 2013 Supplement, section 364.09, is amended to read:

**364.09 EXCEPTIONS.**

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

(1) sections 609.185 to 609.21, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3;

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

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

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

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

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

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

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

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

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

Sec. 58. **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. 59. **REPEALER.**

(a) Minnesota Statutes 2012, sections 148.01, subdivision 3; 148.7808, subdivision 2; and 148.7813, are repealed.

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

(c) Minnesota Rules, parts 2500.0100, subparts 3, 4b, and 9b; and 2500.4000, 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, pre-scripted 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, and, 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.** "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.** "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.** "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, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;
- (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 registered 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 practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse 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. Compounding does not include a minor deviation from such directions with regard to radioactivity, volume, or stability, which is made by or under the supervision of a licensed nuclear pharmacist or a physician, and which is necessary in order to accommodate circumstances not contemplated in the manufacturer's instructions, such as the rate of radioactive decay or geographical distance from the patient.

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.~~

~~(e)~~ (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.~~

**EFFECTIVE DATE.** Subdivisions 1a and 1b are effective August 1, 2014, and apply to violations occurring on or after that date.

### 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 to designated settings; the limitation of the scope of practice within 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) fee splitting, including without limitation:

(i) 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; and

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521;

(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 in-

dividuals 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 professionals 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. A revocation of a license pursuant to subdivision 1 is not appealable and shall remain in effect indefinitely.

**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.** (a) If the board receives a complaint and 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.

(b) Notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, the board may obtain medical data and health records relating to an individual licensed or registered by the board, or to an applicant for licensure or registration, without the individual's consent when the board receives a complaint and has probable cause to believe that the individual is practicing in violation of subdivision 2, clause (14), and the data and health records are limited to the complaint. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

**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. **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.

Subd. 5. **Deadlines; forms.** Reports required by subdivisions 2 to 4 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. 6. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 4 or any related documents.

#### Sec. 5. **[151.073] IMMUNITY.**

Subdivision 1. **Reporting.** 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 as defined in chapter 13.

Subd. 2. **Investigation.** (a) Members of the board and persons employed by the board or engaged on behalf of the board in the investigation of violations and in the preparation and management of charges or violations of this chapter of the rules of the board, or persons participating in the investigation or testifying regarding charges of violations, when acting in good faith, are immune from civil liability for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter or the rules of the board.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability for any actions, transactions, or publications in the execution of, or relating to, their duties under section 151.301.

#### 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. **[151.253] 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:

(1) 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):

(i) that:

(A) 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;

(B) 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

(C) 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);

(ii) 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

(iii) that are accompanied by valid certificates of analysis for each bulk drug substance;

(2) 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;

(3) 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;

(4) does not compound any drug products that are essentially copies of a commercially available drug product; and

(5) 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 dispensing as a professional sample. Samples of a controlled substance shall only be dispensed when one of the approved indications for the controlled substance is a seizure disorder and when the sample is prepared and distributed pursuant to Code of Federal Regulations, title 21, part 203, subpart D.

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, and, 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, and, 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 151.361, 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. 13. 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) phosphodiesterase 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 360bbb-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:

(1) the school is approved by the United States secretary of education in accordance with requirements of the Higher Education Act of 1965, as amended;

(2) the school provides a course of instruction that prepares individuals for employment in a health care occupation or profession;

(3) the school may only possess those drugs necessary for the instruction of such individuals; and

(4) 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. 14. 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 14a.

(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. 15. 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. 16. 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. 17. 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. 18. 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) diethylambutene;
- (15) difenoxin;
- (16) dimenoxadol;
- (17) dimepheptanol;
- (18) dimethylambutene;
- (19) dioxaphetyl butyrate;
- (20) dipipanone;
- (21) ethylmethylthiambutene;
- (22) etonitazene;
- (23) etoxeridine;
- (24) furethidine;
- (25) hydroxypethidine;
- (26) ketobemidone;
- (27) levomoramide;
- (28) levophenacymorphan;

- (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<sub>2</sub>;
- (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) hydromorphanol;
- (13) methyl-desorphine;
- (14) methyldihydromorphine;
- (15) morphine methylbromide;
- (16) morphine methylsulfonate;
- (17) morphine-n-oxide;
- (18) myorphine;
- (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-?-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-?-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-diallyltryptamine (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) fenethylamine;
- (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) methylenedioxypropylamphetamine (MDPV);
- (12) fluoromethcathinone;
- (13) methylethcathinone (MEC);
- (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- (15) dimethylmethcathinone (DMMC);
- (16) fluoroamphetamine;
- (17) fluoromethamphetamine;
- (18) ?-methylaminobutyrophenone (MABP or buphedrone);
- (19) ?-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, alkylendioxy, 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-naphthoyl)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-Butyl-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) Naphthylmethylindoles, 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)methane (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 alkyl, 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 naphthylmethylindenes 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[3.3.1.1<sup>3,7</sup>]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~~ 2016, 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. [144.1212] NOTICE TO PATIENT; MAMMOGRAM RESULTS.

Subdivision 1. **Definition.** For purposes of this section, "facility" has the meaning provided in United States Code, title 42, section 263b(a)(3)(A).

Subd. 2. **Required notice.** A facility at which a mammography examination is performed shall, if a patient is categorized by the facility as having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology, include in the summary of the written report that is sent to the patient, as required by the federal Mam-

mography Quality Standards Act, United States Code, title 42, section 263b, notice that the patient has dense breast tissue, that this may make it more difficult to detect cancer on a mammogram, and that it may increase her risk of breast cancer. The following language may be used:

"Your mammogram shows that your breast tissue is dense. Dense breast tissue is relatively common and is found in more than 40 percent of women. However, dense breast tissue may make it more difficult to identify precancerous lesions or cancer through a mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your own awareness and to help inform your conversations with your treating clinician who has received a report of your mammogram results. Together you can decide which screening options are right for you based on your mammogram results, individual risk factors, or physical examination."

Sec. 3. 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~~ within six months of 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.** The amendment to paragraph (b) is effective the day following final enactment. The amendment to paragraph (a) and paragraph (c) are effective retroactively from August 1, 2013.

Sec. 4. Minnesota Statutes 2012, section 144.414, subdivision 2, is amended to read:

Subd. 2. **Day care premises.** (a) Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation. The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

(b) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

Sec. 5. Minnesota Statutes 2012, section 144.414, subdivision 3, is amended to read:

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well-ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

Sec. 6. Minnesota Statutes 2012, section 144.414, is amended by adding a subdivision to read:

Subd. 5. **Electronic cigarettes.** (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:

(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;

(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;

(3) any facility licensed by the commissioner of human services; or

(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.

(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

Sec. 7. 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 as defined in section 609.685, subdivision 1, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, and no person under the age of 18 shall possess any of these items. 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. 8. 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. 9. 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. 10. Minnesota Statutes 2013 Supplement, section 144.494, subdivision 2, is amended to read:

Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive stroke center, primary stroke center, or acute stroke ready hospital may apply to the commissioner for designation, and upon the commissioner's review and approval of the application, shall be designated as a comprehensive stroke center, a primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke center or primary stroke center from the joint commission or other nationally recognized accreditation entity, or no longer participates in the Minnesota stroke registry program, its Minnesota designation shall be immediately withdrawn. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary acute stroke system may reapply to the commissioner for designation.

Sec. 11. **[144.497] ST ELEVATION MYOCARDIAL INFARCTION.**

The commissioner of health shall assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual;

(2) quarterly post a summary report of the data in aggregate form on the Department of Health Web site;

(3) annually inform the legislative committees with jurisdiction over public health of progress toward improving the quality of care and patient outcomes for ST elevation myocardial infarctions; and

(4) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.

Sec. 12. **[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 presents evidence of 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. 13. Minnesota Statutes 2013 Supplement, section 144A.474, subdivision 8, is amended to read:

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

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

(c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this docu-

mentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

**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. 14. 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 receipt 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. 15. 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. 16. 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. 17. 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 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. 18. Minnesota Statutes 2013 Supplement, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter ~~such as, including advice on the following:~~

- ~~(1) advice to the commissioner regarding~~ (1) community standards for home care practices;
- ~~(2) advice to the commissioner on~~ (2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;
- ~~(3) advice to the commissioner about~~ (3) ways of distributing information to licensees and consumers of home care;
- ~~(4) advice to the commissioner about~~ (4) training standards;
- (5) identify emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities; ~~and~~
- (6) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and
- (7) perform other duties as directed by the commissioner.

Sec. 19. 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. 20. [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, paragraph (b), within 160 working hours of hire, and two hours of training on 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, 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. 21. [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 during the initial staff orientation and annually thereafter and must make emergency and disaster training available to all tenants annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(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. 22. 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. 23. 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. 24. 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. 25. **[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. 26. 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. 27. **[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 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 an 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 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 the owner's 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) must be kept in the location specified in the registration; and

(3) must 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. The authorized agent of the 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. **Civil liability.** This section does not create any civil liability on the part of an AED owner or preclude civil liability under other law. Section 645.241 does not apply to this section.

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

Sec. 28. 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. 29. 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. 30. 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. 31. **[461.20] SALE OF ELECTRONIC DELIVERY DEVICE; PACKAGING.**

(a) For purposes of this section, "child-resistant packaging" is defined as set forth in Code of Federal Regulations, title 16, section 1700.15(b)(1), as in effect on January 1, 2015, when tested in accordance with the method described in Code of Federal Regulations, title 16, section 1700.20, as in effect on January 1, 2015.

(b) The sale of any liquid, whether or not such liquid contains nicotine, that is intended for human consumption and use in an electronic delivery device, as defined in section 609.685, subdivision 1, that is not contained in packaging that is child-resistant, is prohibited. All licensees under this chapter must ensure that any liquid intended for human consumption and use in an electronic delivery device is sold in child-resistant packaging.

(c) A licensee that fails to comply with this section is subject to administrative penalties under section 461.12, subdivision 2.

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

Sec. 32. **[461.21] KIOSK SALES PROHIBITED.**

No person shall sell tobacco, 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, from a moveable place of business. For the purposes of this section, a moveable place of business means any retail business whose physical location is not permanent, including, but not limited to, any retail business that is operated from a kiosk, other transportable structure, or a motorized or nonmotorized vehicle.

**EFFECTIVE DATE.** This section is effective January 1, 2015, for contracts in effect as of May 1, 2014. This section is effective August 1, 2014, for any contracts entered into after May 1, 2014.

Sec. 33. 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. 34. 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. 35. 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. 36. DIRECTION TO COMMISSIONER; TRICLOSAN HEALTH RISKS.**

The commissioner of health shall develop recommendations on ways to minimize triclosan health risks.

**Sec. 37. REPEALER.**

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. 8b. **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. 8a. **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 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.

(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 or county or city that has an established delegation agreement as of January 1, 2014, 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 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. Services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), must comply with the requirements in section 245D.07, subdivision 2.

Sec. 2. 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. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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. 8. 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) adult day services;

(ii) caregiver support;

~~(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 re-assessed 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. 9. Minnesota Statutes 2013 Supplement, section 256B.4912, subdivision 10, is amended to read:

Subd. 10. **Enrollment requirements.** ~~At~~ (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. 10. 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. 11. 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. 12. 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. 13. Minnesota Statutes 2013 Supplement, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

- (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
- (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;
- (3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;
- (4) low cholesterol diet, 25 percent of thrifty food plan;
- (5) high residue diet, 20 percent of thrifty food plan;
- (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
- (7) gluten-free diet, 25 percent of thrifty food plan;
- (8) lactose-free diet, 25 percent of thrifty food plan;
- (9) antidumping diet, 15 percent of thrifty food plan;
- (10) hypoglycemic diet, 15 percent of thrifty food plan; or
- (11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. ~~In a multifamily building of more than four units, the maximum number of units that may be used by recipients of this program shall be the greater of four units or 25 percent of the units in the building, unless required by the Housing Opportunities for Persons with AIDS Program. In multifamily buildings of four or fewer units, all of the units may be used by recipients of this program.~~ When housing is controlled by the service provider, the individual may choose the individual's own service provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is controlled by the service provider, the service provider shall implement a plan with the recipient to transition the lease to the recipient's name. Within two years of signing the initial lease, the service provider shall transfer the lease entered into under this subdivision to the recipient. In the event the landlord denies this transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.

Sec. 14. 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. 15. 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. 16. 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 under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services;

(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. 17. 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~~ 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. 18. 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. 19. 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 waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waived 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. 20. 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. Within existing funding, 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.

## ARTICLE 9

### HEALTH CARE

Section 1. Minnesota Statutes 2013 Supplement, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

- (1) periodontics, limited to periodontal scaling and root planing once every two years;
- (2) general anesthesia; and
- (3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

- (1) posterior fillings are paid at the amalgam rate;
- (2) application of sealants are covered once every five years per permanent molar for children only;
- (3) application of fluoride varnish is covered once every six months; and
- (4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

- (1) house calls or extended care facility calls for on-site delivery of covered services;
- (2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;
- (3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and
- (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Sec. 2. 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. 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 each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

**Sec. 4. 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. 5. **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. **[145.7131] EXCEPTION TO EYEGLOSS PRESCRIPTION EXPIRATION.**

Notwithstanding any practice to the contrary, in an emergency situation or in the case of lost glasses, an optometrist or physician may authorize a new pair of prescription eyeglasses using the prescription from the old lenses or the last prescription available.

Sec. 2. 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 currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 3. 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. 4. 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. 5. 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, are extended.

Sec. 6. 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. 7. 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. 8. 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. 9. 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. 10. **INSTRUCTIONS TO THE COMMISSIONER.**

The commissioner of human services must consult with community stakeholders regarding the impact of the decision of the United States Court of Appeals in Geston v. Anderson, 729 F.3d 1077 (8th Cir. 2013) on the Minnesota medical assistance program. The commissioner must provide a written report to the chairs and ranking minority members of the house of representatives and senate standing committees with jurisdiction over medical assistance policy and finance no later than January 5, 2015. The report must include proposed legislation to ensure Minnesota's medical assistance program complies with the requirements of the Geston decision.

#### Sec. 11. **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. 12. **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. 13. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall remove cross-references to the sections and parts repealed in section 14, 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. 14. **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 12. The commissioner of human services shall notify the revisor of statutes when this occurs.

## ARTICLE 11

### CHILDREN AND FAMILY SERVICES POLICY

Section 1. Minnesota Statutes 2012, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1 (c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision

2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education; or

(30) child support data on the ~~parents and the child, the parents, and relatives of the child~~ may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as ~~provided authorized by federal law. Data may be disclosed only to the extent necessary for the purpose of establishing parentage or for determining who has or may have parental rights with respect to a child, which could be related to permanency planning.~~

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2012, section 119B.02, subdivision 2, is amended to read:

Subd. 2. **Contractual agreements with tribes.** The commissioner may enter into contractual agreements with a federally recognized Indian tribe with a reservation in Minnesota to carry out the responsibilities of county human service agencies to the extent necessary for the tribe to operate child care

assistance programs under sections 119B.03 and 119B.05. An agreement may allow ~~for the tribe to be reimbursed~~ the state to make payments for child care assistance services provided under section 119B.05. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal child care services. Funding to support services under section 119B.03 may be transferred to the federally recognized Indian tribe with a reservation in Minnesota from allocations available to counties in which reservation boundaries lie. When funding is transferred under section 119B.03, the amount shall be commensurate to estimates of the proportion of reservation residents with characteristics identified in section 119B.03, subdivision 6, to the total population of county residents with those same characteristics.

Sec. 3. Minnesota Statutes 2012, section 119B.09, subdivision 6, is amended to read:

Subd. 6. **Maximum child care assistance.** The maximum amount of child care assistance a local agency may authorize pay for in a two-week period is 120 hours per child.

Sec. 4. Minnesota Statutes 2012, section 119B.09, subdivision 13, is amended to read:

Subd. 13. **Child care in the child's home.** (a) Child care assistance must only be authorized in the child's home if:

(1) the child's parents have authorized activities outside of the home ~~and if; or~~

(2) one parent in a two-parent family is in an authorized activity outside of the home and one parent is unable to care for the child and meets the requirements in Minnesota Rules, part 3400.0040, subpart 5.

(b) In order for child care assistance to be authorized under paragraph (a), clause (1) or (2), one or more of the following circumstances ~~are~~ must be met:

(1) the ~~parents' qualifying~~ authorized activity occurs during times when out-of-home care is not available or when out-of-home care would result in disruption of the child's nighttime sleep schedule. If child care is needed during any period when out-of-home care is not available, in-home care can be approved for the entire time care is needed;

(2) the family lives in an area where out-of-home care is not available; or

(3) a child has a verified illness or disability that would place the child or other children in an out-of-home facility at risk or creates a hardship for the child and the family to take the child out of the home to a child care home or center.

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

Sec. 5. Minnesota Statutes 2012, section 256D.05, is amended by adding a subdivision to read:

Subd. 9. **Personal statement.** If a county agency determines that an applicant is ineligible due to not meeting eligibility requirements of this chapter, a county agency may accept a signed personal statement from the applicant in lieu of documentation verifying ineligibility.

Sec. 6. Minnesota Statutes 2012, section 256D.405, subdivision 1, is amended to read:

Subdivision 1. **Verification.** (a) The county agency shall request, and applicants and recipients shall provide and verify, all information necessary to determine initial and continuing eligibility and assistance

payment amounts. If necessary, the county agency shall assist the applicant or recipient in obtaining verifications. If the applicant or recipient refuses or fails without good cause to provide the information or verification, the county agency shall deny or terminate assistance.

(b) If a county agency determines that an applicant is ineligible due to not meeting eligibility requirements of this chapter, a county agency may accept a signed personal statement from the applicant in lieu of documentation verifying ineligibility.

Sec. 7. Minnesota Statutes 2012, section 256E.30, is amended by adding a subdivision to read:

Subd. 2a. **Merger.** In the case of a merger between community action agencies, the newly created agency receives a base funding amount equal to the sum of the merged agencies' base funding amounts at the point of the merger as described in subdivision 2, paragraph (b), unless the commissioner determines the funding amount should be less than the sum of the merged agencies' base funding amount due to savings resulting from fewer redundancies and duplicative services.

Sec. 8. Minnesota Statutes 2012, section 256I.04, subdivision 1a, is amended to read:

Subd. 1a. **County approval.** (a) A county agency may not approve a group residential housing payment for an individual in any setting with a rate in excess of the MSA equivalent rate for more than 30 days in a calendar year unless the county agency has developed or approved a plan for the individual which specifies that:

(1) the individual has an illness or incapacity which prevents the person from living independently in the community; and

(2) the individual's illness or incapacity requires the services which are available in the group residence.

The plan must be signed or countersigned by any of the following employees of the county of financial responsibility: the director of human services or a designee of the director; a social worker; or a case aide.

(b) If a county agency determines that an applicant is ineligible due to not meeting eligibility requirements under this section, a county agency may accept a signed personal statement from the applicant in lieu of documentation verifying ineligibility.

Sec. 9. Minnesota Statutes 2012, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins with the date the signed application is received by the county agency or the date all eligibility criteria are met, whichever is later;

(2) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

(3) inform a person that the person may submit the application before an interview;

(4) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

(5) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

(6) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

(7) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

(8) inform the person that the interview must be conducted face-to-face in the county office, through Internet telepresence, or at a location mutually agreed upon;

(9) inform a person who has received MFIP or DWP in the past 12 months of the option to have a face-to-face, Internet telepresence, or telephone interview;

~~(8)~~ (10) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

~~(9)~~ (11) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 10. Minnesota Statutes 2012, section 256J.20, subdivision 3, is amended to read:

Subd. 3. **Other property limitations.** To be eligible for MFIP, the equity value of all nonexcluded real and personal property of the assistance unit must not exceed \$2,000 for applicants and \$5,000 for ongoing participants. The value of assets in clauses (1) to (19) must be excluded when determining the equity value of real and personal property:

(1) a licensed vehicle up to a ~~loan~~ trade-in value of less than or equal to \$10,000. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the ~~loan~~ trade-in value of all additional vehicles and exclude the combined ~~loan~~ trade-in value of less than or equal to \$7,500. The county agency shall apply any excess ~~loan~~ trade-in value as if it were equity value to the asset limit described in this section, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a disabled member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

To establish the loan trade-in value of vehicles, a county agency must use the N.A.D.A. ~~Official Used Car Guide, Midwest Edition, for newer model cars~~ online car values and car prices guide. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan trade-in value listed in the guidebook online guide as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan trade-in value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan trade-in value;

(2) the value of life insurance policies for members of the assistance unit;

(3) one burial plot per member of an assistance unit;

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

(5) the value of personal property not otherwise specified which is commonly used by household members in day-to-day living such as clothing, necessary household furniture, equipment, and other basic maintenance items essential for daily living;

(6) the value of real and personal property owned by a recipient of Supplemental Security Income or Minnesota supplemental aid;

(7) the value of corrective payments, but only for the month in which the payment is received and for the following month;

(8) a mobile home or other vehicle used by an applicant or participant as the applicant's or participant's home;

(9) money in a separate escrow account that is needed to pay real estate taxes or insurance and that is used for this purpose;

(10) money held in escrow to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, business insurance, property rental, property taxes, and other costs that are paid at least annually, but less often than monthly;

(11) monthly assistance payments for the current month's or short-term emergency needs under section 256J.626, subdivision 2;

(12) the value of school loans, grants, or scholarships for the period they are intended to cover;

(13) payments listed in section 256J.21, subdivision 2, clause (9), which are held in escrow for a period not to exceed three months to replace or repair personal or real property;

(14) income received in a budget month through the end of the payment month;

(15) savings from earned income of a minor child or a minor parent that are set aside in a separate account designated specifically for future education or employment costs;

(16) the federal earned income credit, Minnesota working family credit, state and federal income tax refunds, state homeowners and renters credits under chapter 290A, property tax rebates and other federal or state tax rebates in the month received and the following month;

(17) payments excluded under federal law as long as those payments are held in a separate account from any nonexcluded funds;

(18) the assets of children ineligible to receive MFIP benefits because foster care or adoption assistance payments are made on their behalf; and

(19) the assets of persons whose income is excluded under section 256J.21, subdivision 2, clause (43).

Sec. 11. Minnesota Statutes 2013 Supplement, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, payments for family foster care for children under section 260C.4411 or chapter 256N, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) ~~state adoption or kinship assistance payments under chapter 256N or 259A, and up to an equal amount of county adoption assistance payments~~ Minnesota permanency demonstration title IV-E waiver payments under section 256.01, subdivision 14a;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that

include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment;

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC; and

(48) housing assistance grants under section 256J.35, paragraph (a).

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

Sec. 12. Minnesota Statutes 2013 Supplement, section 256J.24, subdivision 3, is amended to read:

Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

(1) individuals who are recipients of Supplemental Security Income or Minnesota supplemental aid;

(2) individuals disqualified from the food stamp or food support program or MFIP, until the disqualification ends;

(3) children on whose behalf federal, state or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2;

(4) children receiving ongoing guardianship assistance payments under chapter 256N;

~~(4)~~ (5) children receiving ongoing monthly adoption assistance payments under chapter 256N or 259A; and

~~(5)~~ (6) individuals disqualified from the work participation cash benefit program until that disqualification ends.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

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

Sec. 13. Minnesota Statutes 2012, section 256J.30, subdivision 4, is amended to read:

Subd. 4. **Participant's completion of recertification of eligibility form.** A participant must complete forms prescribed by the commissioner which are required for recertification of eligibility according to section 256J.32, subdivision 6. A county agency must end benefits when the participant fails to submit the recertification form and verifications and complete the interview process before the end of the certification period. If the participant submits the recertification form by the last day of the certification period, benefits

may be reinstated back to the date of closing when the recertification process is completed during the first month after benefits ended.

Sec. 14. Minnesota Statutes 2012, section 256J.30, subdivision 12, is amended to read:

Subd. 12. **Requirement to provide Social Security numbers.** Each member of the assistance unit must provide the member's Social Security number to the county agency, except for members in the assistance unit who are qualified noncitizens who are victims of domestic violence as defined under section 256J.08, subdivision 73, ~~clause (7)~~ clauses (8) and (9). When a Social Security number is not provided to the county agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

Sec. 15. Minnesota Statutes 2012, section 256J.32, subdivision 6, is amended to read:

Subd. 6. **Recertification.** (a) The county agency shall recertify eligibility in an annual face-to-face interview with the participant. ~~The county agency may waive the face-to-face interview and conduct a phone interview for participants who qualify under paragraph (b).~~ The interview may be conducted by phone, Internet telepresence, or face-to-face in the county office or in another location mutually agreed upon. During the interview, the county agency shall verify the following:

- (1) presence of the minor child in the home, if questionable;
- (2) income, unless excluded, including self-employment expenses used as a deduction or deposits or withdrawals from business accounts;
- (3) assets when the value is within \$200 of the asset limit;
- (4) information to establish an exception under section 256J.24, subdivision 9, if questionable;
- (5) inconsistent information, if related to eligibility; and
- (6) whether a single caregiver household meets requirements in section 256J.575, subdivision 3.

(b) ~~A participant who is employed any number of hours must be given the option of conducting a face-to-face or a phone interview or Internet telepresence to recertify eligibility. The participant must be employed at the time the interview is scheduled. If the participant loses the participant's job between the time the interview is scheduled and when it is to be conducted, the phone interview may still be conducted.~~

Sec. 16. Minnesota Statutes 2012, section 256J.32, subdivision 8, is amended to read:

Subd. 8. **Personal statement.** (a) The county agency may accept a signed personal statement from the applicant or participant explaining the reasons that the documentation requested in subdivision 2 is unavailable as sufficient documentation at the time of application, recertification, or change related to eligibility only for the following factors:

- (1) a claim of family violence if used as a basis to qualify for the family violence waiver;
- (2) information needed to establish an exception under section 256J.24, subdivision 9;
- (3) relationship of a minor child to caregivers in the assistance unit;

(4) citizenship status from a noncitizen who reports to be, or is identified as, a victim of severe forms of trafficking in persons, if the noncitizen reports that the noncitizen's immigration documents are being held by an individual or group of individuals against the noncitizen's will. The noncitizen must follow up with the Office of Refugee Resettlement (ORR) to pursue certification. If verification that certification is being pursued is not received within 30 days, the MFIP case must be closed and the agency shall pursue overpayments. The ORR documents certifying the noncitizen's status as a victim of severe forms of trafficking in persons, or the reason for the delay in processing, must be received within 90 days, or the MFIP case must be closed and the agency shall pursue overpayments; and

(5) other documentation unavailable for reasons beyond the control of the applicant or participant. Reasonable attempts must have been made to obtain the documents requested under subdivision 2.

(b) After meeting all requirements under section 256J.09, if a county agency determines that an applicant is ineligible due to exceeding limits under sections 256J.20 and 256J.21, a county agency may accept a signed personal statement from the applicant in lieu of documentation verifying ineligibility.

Sec. 17. Minnesota Statutes 2012, section 256J.38, subdivision 6, is amended to read:

Subd. 6. **Scope of underpayments.** A county agency must issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Corrective payments are limited to 12 months prior to the month of discovery. The county agency must issue the corrective payment according to subdivision 8.

Sec. 18. Minnesota Statutes 2012, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **Work activity.** (a) "Work activity" means any activity in a participant's approved employment plan that leads to employment. For purposes of the MFIP program, this includes activities that meet the definition of work activity under the participation requirements of TANF. Work activity includes:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, paid work experience, and supported work when a wage subsidy is provided;

(3) ~~unpaid uncompensated~~ work experience, including community service, ~~volunteer work~~, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. ~~Unpaid Uncompensated~~ work experience is only an option if the participant has been unable to obtain or maintain paid employment in the competitive labor market, and no paid work experience programs are available to the participant. Prior to placing a participant in ~~unpaid uncompensated~~ work, the county must inform the participant that the participant will be notified if a paid work experience or supported work position becomes available. Unless a participant consents in writing to participate in ~~unpaid uncompensated~~ work experience, the participant's employment plan may only include ~~unpaid uncompensated~~ work experience if ~~including the unpaid work experience in the plan will meet the following criteria are met:~~

(i) the ~~unpaid uncompensated~~ work experience will provide the participant specific skills or experience that cannot be obtained through other work activity options where the participant resides or is willing to reside; and

(ii) the skills or experience gained through the ~~unpaid~~ uncompensated work experience will result in higher wages for the participant than the participant could earn without the ~~unpaid~~ uncompensated work experience;

(4) job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes as limited by the provisions of section 256J.531, subdivision 2, general educational development (GED) course work, high school completion, and adult basic education as limited by the provisions of section 256J.531, subdivision 1;

(6) job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

(b) "Work activity" does not include activities done for political purposes as defined in section 211B.01, subdivision 6.

Sec. 19. Minnesota Statutes 2012, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. **Assessments.** (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, as appropriate, to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to family stabilization services under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. ~~The commissioner shall work with county~~

~~agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d) three months after development of the initial employment plan or earlier if there is a documented need. Failure to complete the screens will result in sanction under section 256J.46; and~~

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to family stabilization services under section 256J.575.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 20. Minnesota Statutes 2012, section 256J.521, subdivision 2, is amended to read:

Subd. 2. **Employment plan; contents.** (a) Based on the assessment under subdivision 1, the job counselor and the participant must develop an employment plan that includes participation in activities and hours that meet the requirements of section 256J.55, subdivision 1. The purpose of the employment plan is to identify for each participant the most direct path to unsubsidized employment and any subsequent steps that support long-term economic stability. The employment plan should be developed using the highest level of activity appropriate for the participant. Activities must be chosen from clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of preference for activities, priority must be given for activities related to a family violence waiver when developing the employment plan. The employment plan must also list the specific steps the participant will take to obtain employment, including steps necessary for the participant to progress from one level of activity to another, and a timetable for completion of each step. Levels of activity include:

- (1) unsubsidized employment;
- (2) job search;
- (3) subsidized employment or unpaid work experience;
- (4) unsubsidized employment and job readiness education or job skills training;

(5) unsubsidized employment or unpaid work experience and activities related to a family violence waiver or preemployment needs; and

(6) activities related to a family violence waiver or preemployment needs.

(b) Participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment must job search at least 30 hours per week for up to ~~six weeks~~ three months and accept any offer of suitable employment. The remaining hours necessary to meet the requirements of section 256J.55, subdivision 1, may be met through participation in other work activities under section 256J.49, subdivision 13. The participant's employment plan must specify, at a minimum: (1) whether the job search is ~~supervised or unsupervised on site or self-directed~~; (2) support services that will be provided; and (3) how frequently the participant must report to the job counselor. Participants who are unable to find suitable employment after ~~six weeks~~ three months must meet with the job counselor to determine whether other activities in paragraph (a) should be incorporated into the employment plan. Job search activities which are continued after ~~six weeks~~ three months must be structured and supervised.

(c) Participants who are determined to have barriers to obtaining or maintaining suitable employment that will not be overcome during ~~six weeks~~ three months of job search under paragraph (b) must work with the job counselor to develop an employment plan that addresses those barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6). The employment plan must include enough hours to meet the participation requirements in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours is noted in the participant's file.

(d) The job counselor and the participant must sign the employment plan to indicate agreement on the contents.

(e) Except as provided under paragraph (f), failure to develop or comply with activities in the plan, or voluntarily quitting suitable employment without good cause, will result in the imposition of a sanction under section 256J.46.

(f) When a participant fails to meet the agreed-upon hours of participation in paid employment because the participant is not eligible for holiday pay and the participant's place of employment is closed for a holiday, the job counselor shall not impose a sanction or increase the hours of participation in any other activity, including paid employment, to offset the hours that were missed due to the holiday.

(g) Employment plans must be reviewed at least every three months to determine whether activities and hourly requirements should be revised. The job counselor is encouraged to allow participants who are participating in at least 20 hours of work activities to also participate in education and training activities in order to meet the federal hourly participation rates.

Sec. 21. Minnesota Statutes 2012, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35.

(b) Participants seeking approval of a postsecondary education or training plan must ~~provide documentation~~ work with the job counselor to document that:

(1) the employment goal can only be met with the additional education or training;

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

Sec. 22. Minnesota Statutes 2012, section 256J.53, subdivision 5, is amended to read:

Subd. 5. **Requirements after postsecondary education or training.** Upon completion of an approved education or training program, a participant who does not meet the participation requirements in section 256J.55, subdivision 1, through unsubsidized employment must participate in job search. If, after ~~six weeks~~ three months of job search, the participant does not find a full-time job consistent with the employment goal, the participant must accept any offer of full-time suitable employment, or meet with the job counselor to revise the employment plan to include additional work activities necessary to meet hourly requirements.

Sec. 23. Minnesota Statutes 2013 Supplement, section 256J.621, subdivision 1, is amended to read:

Subdivision 1. **Program characteristics.** (a) ~~Effective October 1, 2009, upon exiting the diversionary work program (DWP) or upon terminating~~ Within 30 days of exiting the Minnesota family investment program with earnings, a participant who is employed may be eligible the county must assess eligibility for work participation cash benefits of \$25 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency. Payment begins effective the first of the month following exit or termination for MFIP and DWP participants.

(b) To be eligible for work participation cash benefits, the participant shall not receive MFIP or diversionary work program assistance during the month and the participant or participants must meet the following work requirements:

(1) if the participant is a single caregiver and has a child under six years of age, the participant must be employed at least 87 hours per month;

(2) if the participant is a single caregiver and does not have a child under six years of age, the participant must be employed at least 130 hours per month; or

(3) if the household is a two-parent family, at least one of the parents must be employed 130 hours per month.

Whenever a participant exits the diversionary work program or is terminated from MFIP and meets the other criteria in this section, work participation cash benefits are available for up to 24 consecutive months.

(c) Expenditures on the program are maintenance of effort state funds under a separate state program for participants under paragraph (b), clauses (1) and (2). Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort funds. Months in which a participant receives work participation cash benefits under this section do not count toward the participant's MFIP 60-month time limit.

Sec. 24. Minnesota Statutes 2012, section 256J.626, subdivision 5, is amended to read:

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than \$3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner ~~for projects testing to reward high-performing counties and tribes, support promising practices, and test innovative approaches to improving outcomes for MFIP participants, family stabilization services participants, and persons at risk of receiving MFIP as detailed in subdivision 3.~~ Project funds may be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes.

Sec. 25. Minnesota Statutes 2013 Supplement, section 256J.626, subdivision 6, is amended to read:

Subd. 6. **Base allocation to counties and tribes; definitions.** (a) For purposes of this section, the following terms have the meanings given.

(1) "2002 historic spending base" means the commissioner's determination of the sum of the reimbursement related to fiscal year 2002 of county or tribal agency expenditures for the base programs listed in clause (6), items (i) through (iv), and earnings related to calendar year 2002 in the base program listed in clause (6), item (v), and the amount of spending in fiscal year 2002 in the base program listed in clause (6), item (vi), issued to or on behalf of persons residing in the county or tribal service delivery area.

(2) "Adjusted caseload factor" means a factor weighted:

(i) 47 percent on the MFIP cases in each county at four points in time in the most recent 12-month period for which data is available multiplied by the county's caseload difficulty factor; and

(ii) 53 percent on the count of adults on MFIP in each county and tribe at four points in time in the most recent 12-month period for which data is available multiplied by the county or tribe's caseload difficulty factor.

(3) "Caseload difficulty factor" means a factor determined by the commissioner for each county and tribe based upon the self-support index described in section 256J.751, subdivision 2, clause (6).

(4) "Initial allocation" means the amount potentially available to each county or tribe based on the formula in paragraphs (b) through (d).

(5) "Final allocation" means the amount available to each county or tribe based on the formula in paragraphs (b) through (d), after adjustment by subdivision 7.

(6) "Base programs" means the:

(i) MFIP employment and training services under Minnesota Statutes 2002, section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under Minnesota Statutes 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under Minnesota Statutes 2002, section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June 30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48, in effect June 30, 2002.

(b) The commissioner shall determine for calendar year 2008 and subsequent years the initial allocation of funds to be made available under this section based 50 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 50 percent on the proportion of the county or tribe's share of the adjusted caseload factor.

(c) With the commencement of a new or expanded tribal TANF program, or for tribes administering TANF as authorized under Laws 2011, First Special Session chapter 9, article 9, section 18, or an agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of the responsibilities of particular counties under this section are transferred to a tribe, the commissioner shall:

(1) in the case where all responsibilities under this section are transferred to a tribe or tribal program, determine the percentage of the county's current caseload that is transferring to a tribal program and adjust the affected county's allocation and tribe's allocations accordingly; and

(2) in the case where a portion of the responsibilities under this section are transferred to a tribe or tribal program, the commissioner shall consult with the affected county or counties to determine an appropriate adjustment to the allocation.

(d) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.

Sec. 26. Minnesota Statutes 2012, section 256J.626, subdivision 8, is amended to read:

Subd. 8. **Reporting requirement and reimbursement.** (a) The commissioner shall specify requirements for reporting according to section 256.01, subdivision 2, clause (17). Each county or tribe shall be reimbursed for eligible expenditures up to the limit of its allocation and subject to availability of funds.

(b) Reimbursements for county administrative-related expenditures determined through the income maintenance random moment time study shall be reimbursed at a rate of 50 percent of eligible expenditures.

(c) The commissioner of human services shall review county and tribal agency expenditures of the MFIP consolidated fund as appropriate and may reallocate unencumbered or unexpended money appropriated under this section to those county and tribal agencies that can demonstrate a need for additional money as follows:

~~(1) to the extent that particular county or tribal allocations are reduced from the previous year's amount due to the phase-in under subdivision 6, paragraph (b), clauses (4) to (6), those tribes or counties would have first priority for reallocated funds; and~~

~~(2) To the extent that unexpended funds are insufficient to cover demonstrated need, funds will~~ must be prorated to those counties and tribes in relation to demonstrated need.

Sec. 27. Minnesota Statutes 2012, section 256J.67, is amended to read:

#### **256J.67 COMMUNITY WORK EXPERIENCE.**

Subdivision 1. **Establishing the community work experience program.** To the extent of available resources, each county agency may establish and operate a community work experience component for MFIP caregivers who are participating in employment and training services. This option for county agencies supersedes the requirement in section 402(a)(1)(B)(iv) of the Social Security Act that caregivers who have received assistance for two months and who are not exempt from work requirements must participate in a work experience program. The purpose of the community work experience component is to enhance the caregiver's employability and self-sufficiency and to provide meaningful, productive work activities. The county shall use this program for an individual after exhausting all other employment opportunities. The county agency shall not require a caregiver to participate in the community work experience program unless the caregiver has been given an opportunity to participate in other work activities.

Subd. 2. **Commissioner's duties.** The commissioner shall assist counties in the design and implementation of these components.

Subd. 3. **Employment options.** (a) Work sites developed under this section are limited to projects that serve a useful public service such as: health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, the prior training, skills, and experience of a caregiver must be considered in making appropriate work experience assignments.

(b) Structured, supervised ~~volunteer~~ uncompensated work with an agency or organization, which is monitored by the county service provider, may, with the approval of the county agency, be used as a community work experience placement.

(c) As a condition of placing a caregiver in a program under this section, the county agency shall first provide the caregiver the opportunity:

(1) for placement in suitable subsidized ~~or unsubsidized~~ employment through participation in a job search; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

Subd. 4. **Employment plan.** (a) The caretaker's employment plan must include the length of time needed in the community work experience program, the need to continue job-seeking activities while participating in community work experience, and the caregiver's employment goals.

(b) After each six months of a caregiver's participation in a community work experience job placement, and at the conclusion of each community work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the caregiver's employment plan.

(c) A caregiver may claim good cause under section 256J.57, subdivision 1, for failure to cooperate with a community work experience job placement.

(d) The county agency shall limit the maximum number of hours any participant may work under this section to the amount of the MFIP standard of need divided by the federal or applicable state minimum wage, whichever is higher. After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the MFIP standard of need divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site. This limit does not apply if it would prevent a participant from counting toward the federal work participation rate.

Sec. 28. Minnesota Statutes 2012, section 256J.68, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) This section must be used to determine payment of any claims resulting from an alleged injury or death of a person participating in a county or a tribal ~~community~~ uncompensated work experience program under section 256J.49, subdivision 13, paragraph (a), clause (3), that is approved by the commissioner and is operated by:

- (1) the county agency;
- (2) the tribe;
- (3) a ~~department of the state~~ agency; or

(4) a community-based organization under contract, ~~prior to April 1, 1997, with a tribe or county agency to provide a community an uncompensated work experience program or a food stamp community work experience employment and training program, provided the organization has not experienced any individual injury loss or claim greater than \$1,000 under section 256D.051.~~

~~(b) This determination method is available to the community-based organization under paragraph (a), clause (4), only for claims incurred by participants in the community work experience program or the food stamp community work experience program.~~

~~(e) (b) This determination method section applies to the community work experience program under section 256J.67, the Supplemental Nutrition Assistance Program uncompensated work experience programs authorized, and other uncompensated work programs approved by the commissioner for persons applying for or receiving cash assistance and food stamps, and to the Minnesota parent's fair share program, in a county with an approved community investment program for obligors. Uncompensated work experience programs are considered to be approved by the commissioner if they are included in an approved tribal or county biennial service agreement under section 256J.626, subdivision 4.~~

Sec. 29. Minnesota Statutes 2012, section 256J.68, subdivision 2, is amended to read:

Subd. 2. **Investigation of the claim.** Claims that are subject to this section must be investigated by the county agency or ~~the tribal program~~ tribe responsible for ~~supervising the placing a participant in an uncompensated work experience program~~ to determine whether the claimed injury occurred, whether the claimed medical expenses are reasonable, and whether the loss is covered by the claimant's insurance. If insurance coverage is established, the county agency or ~~tribal program~~ tribe shall submit the claim to the appropriate insurance entity for payment. The investigating county agency or ~~tribal program~~ tribe shall submit all ~~valid~~ remaining claims, in the amount net of any insurance payments, to the Department of Human Services.

Sec. 30. Minnesota Statutes 2012, section 256J.68, subdivision 4, is amended to read:

Subd. 4. **Claims less than \$1,000.** The commissioner shall approve a claim of \$1,000 or less for payment if appropriated funds are available, if the county agency or ~~tribal program~~ tribe responsible for ~~supervising the placing a participant in an uncompensated work experience program~~ has made the determinations required by this section, and if the work program was operated in compliance with the safety provisions of this section. The commissioner shall pay the portion of an approved claim of \$1,000 or less that is not covered by the claimant's insurance within three months of the date of submission. On or before February 1 of each year, the commissioner shall submit to the appropriate committees of the senate and the

house of representatives a list of claims of \$1,000 or less paid during the preceding calendar year and shall be reimbursed by legislative appropriation for any claims that exceed the original appropriation provided to the commissioner to operate ~~this program~~ the injury protection program for uncompensated work experience participants. Any unspent money from this appropriation shall carry over to the second year of the biennium, and any unspent money remaining at the end of the second year shall be returned to the state general fund.

Sec. 31. Minnesota Statutes 2012, section 256J.68, subdivision 7, is amended to read:

Subd. 7. **Exclusive procedure.** ~~The procedure~~ procedures established by this section ~~is~~ apply to uncompensated work experience programs under subdivision 1 and are exclusive of all other legal, equitable, and statutory remedies against the state, its political subdivisions, or employees of the state or its political subdivisions under section 13.02, subdivision 11. The claimant shall not be entitled to seek damages from any state, county, tribal, or reservation insurance policy or self-insurance program. A provider who accepts or agrees to accept an injury protection program payment for services provided to an individual must not require any payment from the individual.

Sec. 32. Minnesota Statutes 2012, section 256J.68, subdivision 8, is amended to read:

Subd. 8. **Invalid claims.** A claim is ~~not valid~~ invalid for purposes of this section if the county agency or tribe responsible for ~~supervising the work~~ placing a participant cannot verify to the commissioner:

(1) that appropriate safety training and information is provided to all persons being supervised by the ~~agency~~ uncompensated work experience site under this section; and

(2) that all programs ~~involving work by those persons~~ under subdivision 1 comply with federal Occupational Safety and Health Administration and state Department of Labor and Industry safety standards. ~~A claim that is not valid because of~~ An invalid claim due to a failure to verify safety training or compliance with safety standards will not be paid by the Department of Human Services or through the legislative claims process and must be heard, decided, and paid, if appropriate, by the local government unit county agency or tribal program tribe responsible for ~~supervising the work of~~ placing the claimant.

Sec. 33. Minnesota Statutes 2012, section 256J.751, subdivision 2, is amended to read:

Subd. 2. **Quarterly comparison report.** (a) The commissioner shall report quarterly to all counties on each county's performance on the following measures:

- (1) percent of MFIP caseload working in paid employment;
- (2) percent of MFIP caseload receiving only the food portion of assistance;
- (3) number of MFIP cases that have left assistance;
- (4) median placement wage rate;
- (5) caseload by months of TANF assistance;

(6) percent of MFIP and diversionary work program (DWP) cases off cash assistance or working 30 or more hours per week at one-year, two-year, and three-year follow-up points from a baseline quarter. This measure is called the self-support index. The commissioner shall report quarterly an expected range of performance for each county, county grouping, and tribe on the self-support index. The expected range shall

be derived by a statistical methodology developed by the commissioner in consultation with the counties and tribes. The statistical methodology shall control differences across counties in economic conditions and demographics of the MFIP and DWP case load; and

(7) the TANF work participation rate, defined as the participation requirements specified under Public Law 109-171, the Deficit Reduction Act of 2005.

(b) The commissioner shall not apply the limits on vocational educational training and education activities under Code of Federal Regulations, title 45, section 261.33(c), when determining TANF work participation rates for individual counties under this subdivision.

Sec. 34. Minnesota Statutes 2012, section 256K.26, subdivision 4, is amended to read:

Subd. 4. **County Eligibility.** Counties and tribes are eligible for funding under this section. Priority will be given to proposals submitted on behalf of multicounty and tribal partnerships.

Sec. 35. **[260D.12] TRIAL HOME VISITS; VOLUNTARY FOSTER CARE FOR TREATMENT.**

When a child is in foster care for treatment under this chapter, the child's parent and the responsible social services agency may agree that the child is returned to the care of the parent on a trial home visit. The purpose of the trial home visit is to provide sufficient planning for supports and services to the child and family to meet the child's needs following treatment so that the child can return to and remain in the parent's home. During the period of the trial home visit, the agency has placement and care responsibility for the child. The trial home visit shall not exceed six months and may be terminated by either the parent or the agency within ten days' written notice.

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

Sec. 36. Minnesota Statutes 2013 Supplement, section 626.556, subdivision 7, is amended to read:

Subd. 7. **Report; information provided to parent.** (a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under subdivision 3 to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for assessing or investigating the report, or the local welfare agency, ~~unless the appropriate agency has informed the reporter that the oral information does not constitute a report under subdivision 10.~~ The local welfare agency shall determine if the report is accepted for an assessment or investigation as soon as possible but in no event longer than 24 hours after the report is received.

(b) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the abuse or neglect of the child if the person is known, the nature and extent of the abuse or neglect and the name and address of the reporter. ~~If requested, the local welfare agency or the agency responsible for assessing or investigating the report shall inform the reporter within ten days after the report is made, either orally or in writing, whether the report was accepted for assessment or investigation.~~ The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under subdivision 3 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph. Written reports received by a police department or the county sheriff shall be forwarded immediately to the local welfare agency or the agency responsible for assessing or investigating the report. The police department or the county sheriff may keep copies of reports

received by them. Copies of written reports received by a local welfare department or the agency responsible for assessing or investigating the report shall be forwarded immediately to the local police department or the county sheriff.

(c) When requested, the agency responsible for assessing or investigating a report shall inform the reporter within ten days after the report was made, either orally or in writing, whether the report was accepted or not. If the responsible agency determines the report does not constitute a report under this section, the agency shall advise the reporter the report was screened out. A screened-out report must not be used for any purpose other than making an offer of social services to the subjects of the screened-out report.

~~(b)~~ (d) Notwithstanding paragraph (a), the commissioner of education must inform the parent, guardian, or legal custodian of the child who is the subject of a report of alleged maltreatment in a school facility within ten days of receiving the report, either orally or in writing, whether the commissioner is assessing or investigating the report of alleged maltreatment.

~~(e)~~ (e) Regardless of whether a report is made under this subdivision, as soon as practicable after a school receives information regarding an incident that may constitute maltreatment of a child in a school facility, the school shall inform the parent, legal guardian, or custodian of the child that an incident has occurred that may constitute maltreatment of the child, when the incident occurred, and the nature of the conduct that may constitute maltreatment.

~~(d)~~ (f) A written copy of a report maintained by personnel of agencies, other than welfare or law enforcement agencies, which are subject to chapter 13 shall be confidential. An individual subject of the report may obtain access to the original report as provided by subdivision 11.

Sec. 37. 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 after the date of the final entry in the case record. 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.

Sec. 38. Minnesota Statutes 2012, section 626.5561, subdivision 1, is amended to read:

Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person mandated to report under section 626.556, subdivision 3, shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(b) A health care professional or a social service professional who is mandated to report under section 626.556, subdivision 3, is exempt from reporting under paragraph (a) a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy if the professional is providing the woman with prenatal care or other healthcare services.

(c) Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(d) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter. The local welfare agency shall accept a report made under paragraph (c) notwithstanding refusal by a voluntary reporter to provide the reporter's name or address as long as the report is otherwise sufficient.

~~(d)~~ (e) For purposes of this section, "prenatal care" means the comprehensive package of medical and psychological support provided throughout the pregnancy.

## ARTICLE 12

### APPROPRIATIONS

	<u>APPROPRIATIONS</u>	
	<u>Available for the Year</u>	
	<u>Ending June 30</u>	
	<u>2014</u>	<u>2015</u>
Section 1. <u>APPROPRIATIONS</u>	\$	\$
<u>Board of Behavioral Health and Therapy</u>	<u>-0-</u>	<u>8,000</u>

This appropriation is from the state government special revenue fund for board member per diem payments and licensing activity.

<b><u>Board of Chiropractic Examiners</u></b>	<u>-0-</u>	<u>10,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Dentistry</u></b>	<u>-0-</u>	<u>39,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Dietetics and Nutrition Practice</u></b>	<u>-0-</u>	<u>1,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Marriage and Family Therapy</u></b>	<u>-0-</u>	<u>4,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments and licensing activity.</u>		
<b><u>Board of Medical Practice</u></b>	<u>-0-</u>	<u>38,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Nursing</u></b>	<u>-0-</u>	<u>266,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments and licensing activity.</u>		
<b><u>Board of Nursing Home Administrators</u></b>	<u>-0-</u>	<u>2,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Optometry</u></b>	<u>-0-</u>	<u>1,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Pharmacy</u></b>	<u>-0-</u>	<u>2,000</u>
<u>This appropriation is from the state government special revenue fund for board member per diem payments.</u>		
<b><u>Board of Physical Therapy</u></b>	<u>-0-</u>	<u>4,000</u>

This appropriation is from the state government special revenue fund for board member per diem payments.

**Board of Podiatric Medicine** -0- 1,000

This appropriation is from the state government special revenue fund for board member per diem payments.

**Board of Psychology** -0- 15,000

This appropriation is from the state government special revenue fund for board member per diem payments.

**Board of Social Work** -0- 17,000

This appropriation is from the state government special revenue fund for board member per diem payments and licensing activity.

**Board of Veterinary Medicine** -0- 2,000

This appropriation is from the state government special revenue fund for board member per diem payments.

Sec. 2. **APPROPRIATION.**

\$210,000 in fiscal year 2015 is appropriated from the state government special revenue fund to the Board of Pharmacy to implement changes to the prescription monitoring program. The base for this appropriation is \$171,000 in fiscal years 2016 and 2017.

Presented to the governor May 17, 2014

Signed by the governor May 21, 2014, 10:58 a.m.