CHAPTER 144

DEPARTMENT OF HEALTH

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under sections 144.072 and 144.0721, or under rules established by the commissioner of human services under sections 256B.41 to 256B.48. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within ten working days of the receipt of the notice of resident classification. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did

not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

History: *1Sp1985 c 3 s 1*

144.126 PHENYLKETONURIA TESTING PROGRAM.

The commissioner shall provide on a statewide basis without charge to the recipient, treatment control tests for which approved laboratory procedures are available for phenylketonuria and other metabolic diseases causing mental retardation.

History: *1Sp1985 c 9 art 2 s 9*

144.128 TREATMENT FOR POSITIVE DIAGNOSIS, REGISTRY OF CASES.

The commissioner shall:

(1) make arrangements for the necessary treatment of diagnosed cases of phenylketonuria and other metabolic diseases when treatment is indicated and the family is uninsured and, because of a lack of available income, is unable to pay the cost of the treatment;

(2) maintain a registry of cases of phenylketonuria and other metabolic diseases for the purpose of follow-up services to prevent mental retardation; and

(3) adopt rules to carry out section 144.126 and this section.

History: *1Sp1985 c 9 art 2 s 10*

144.335 ACCESS TO HEALTH RECORDS.

[For text of subd 1, see M.S.1984]

Subd. 2. **Patient access.** (a) Upon request a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

(b) Upon a patient's written request, a provider at a reasonable cost to the patient shall furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's health condition, (2) the pertinent portion of the record relating to a specific condition, or (3) a summary of the record.

(c) If a provider, as defined in subdivision 1, clause (b) (1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm himself or another, he may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in subdivision 1, clause (b) (1). The other provider or third party may release the information to the patient.

(d) A provider as defined in subdivision 1, clause (b) (2), shall release information upon written request unless, prior to the request, a provider as defined in subdivision 1, clause (b) (1), has designated and described a specific basis for withholding the information as authorized by paragraph (c).

[For text of subds 3 and 4, see M.S.1984]

History: *1985 c 298 s 40*

144.391 PUBLIC POLICY.

The legislature finds that:

(1) smoking causes premature death, disability, and chronic disease, including cancer and heart disease, and lung disease;

(2) smoking related diseases result in excess medical care costs; and

(3) smoking initiation occurs primarily in adolescence.

The legislature desires to prevent young people from starting to smoke, to encourage and assist smokers to quit, and to promote clean indoor air.

History: *1Sp1985 c 14 art 19 s 13*

144.392 DUTIES OF THE COMMISSIONER.

The commissioner of health shall:

(1) provide assistance to workplaces to develop policies that promote nonsmoking and are consistent with the Minnesota clean indoor air act;

(2) provide technical assistance, including design and evaluation methods, materials, and training to local health departments, communities, and other organizations that undertake community programs for the promotion of nonsmoking;

(3) collect and disseminate information and materials for smoking prevention;

(4) evaluate new and existing nonsmoking programs on a statewide and regional basis using scientific evaluation methods;

(5) conduct surveys in school-based populations regarding the epidemiology of smoking behavior, knowledge, and attitudes related to smoking, and the penetration of statewide smoking control programs; and

(6) report to the legislature each biennium on activities undertaken, smoking rates in the population and subgroups of the total population, evaluation activities and results of those activities, and recommendations for further action.

History: *1Sp1985 c 14 art 19 s 14*

144.393 PUBLIC COMMUNICATIONS PROGRAM.

The commissioner may conduct a long-term coordinated public information program that includes public service announcements, public education forums, mass media, and written materials. The program must promote nonsmoking and include background survey research and evaluation. The program must be designed to run over at least five years, subject to the availability of money.

History: *1Sp1985 c 14 art 19 s 15*

144.491 COMMISSIONER'S DUTIES RELATING TO LEAD ABSORPTION.

The commissioner of health shall:

(1) provide coordination and advice to community programs that test children for lead in their blood to assure that these testing services are conducted in a safe and appropriate manner, are targeted to children throughout the state at risk to lead contamination or absorption, and generate data that may be analyzed on a statewide basis;

(2) provide coordination and advice of local lead absorption testing programs, to assure adequate skill and efficiency, to the laboratories within the state that conduct Erythrocyte Protoporphorin testing, confirmatory blood lead testing, and testing of paint chips and other environmental lead sources;

(3) provide public and professional education concerning lead contamination or absorption and its health effects on children;

(4) review state and local housing codes and advise the governing bodies and administrative departments adopting or administering the codes to insure that the hazard of absorption and contamination from leaded paint is adequately addressed and considered, and provide technical support for enforcement of the codes by local health departments and local building inspection departments; and

(5) study and determine the extent of exposure to lead in drinking water caused by plumbing and develop recommendations and techniques for reducing this exposure.

History: *1Sp1985 c 14 art 19 s 16*

144.495 FORMALDEHYDE RULES.

The legislature finds that building materials containing urea formaldehyde may emit unsafe levels of formaldehyde in newly constructed housing units. The product standards prescribed in section 325F.181 are intended to provide indoor air levels of formaldehyde that do not exceed 0.4 parts per million. If the commissioner of health determines that the standards prescribed in section 325F.181 result in indoor air levels of formaldehyde that exceed 0.4 parts per million, the commissioner may adopt different building materials product standards to ensure that the 0.4 parts per million level is not exceeded. The commissioner may adopt rules under chapter 14 to establish product standards as provided in this section. The rules of the commissioner governing ambient air levels of formaldehyde, Minnesota Rules, parts 4620.1600 to 4620.2100, are repealed, except that the rule of the commissioner relating to new installations of urea formaldehyde foam insulation in residential housing units remains in effect.

History: *1985 c 216 s 1*

144.50 HOSPITALS, LICENSES; DEFINITIONS.

[For text of subd 1, see M.S.1984]

Subd. 2. Hospital, sanatorium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's office or to hotels or other similar places that furnish only board and room, or either, to their guests.

[For text of subds 3 and 5, see M.S.1984]

History: *1Sp1985 c 3 s 2*

144.562 SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS; VIOLATIONS.

Subdivision 1. **Definition.** For the purposes of this section, "swing bed" means a hospital bed licensed under sections 144.50 to 144.56 that has been granted a

license condition under this section and which has been certified to participate in the federal medicare program under United States Code, title 42, section 1395 (tt).

Subd. 2. **Eligibility for license condition.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for medicare reimbursement before May 1, 1985; (2) it is located in a rural area as defined in the federal medicare regulations, Code of Federal Regulations, title 42, section 405.1041; and (3) it agrees to utilize no more than four hospital beds as swing beds at any one time, except that the commissioner may approve the utilization of up to three additional beds at the request of a hospital if no medicare certified skilled nursing facility beds are available within 25 miles of that hospital.

Subd. 3. **Approval of license condition.** The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision:

(a) The hospital must meet the eligibility criteria in subdivision 2.

(b) The hospital must be in compliance with the medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 405.1041.

(c) The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(d) The hospital must agree, in writing, to limit admission to a swing bed only to patients who have been hospitalized and not yet discharged from the facility.

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(f) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

Subd. 4. **Issuance of license condition; renewals.** The commissioner of health shall issue a license condition to a hospital that complies with subdivisions 2 and 3.

The license condition must be granted when the license is first issued, when it is renewed, or during the hospital's licensure year. The condition is valid for the hospital's licensure year. The license condition can be renewed at the time of the hospital's license renewal if the hospital complies with subdivisions 2 and 3.

Subd. 5. **Inspections.** Notwithstanding section 144.55, subdivision 4, the commissioner of health may conduct inspections of a hospital granted a condition under this section to assess compliance with this section.

Subd. 6. **Violations.** Notwithstanding section 144.55, subdivision 4, if the hospital fails to comply with subdivision 2 or 3, the commissioner of health shall issue a correction order and penalty assessment under section 144.653 or may suspend, revoke, or refuse to renew the license condition under section 144.55, subdivision 6. The penalty assessment for a violation of subdivision 2 or 3 is $500.

Subd. 7. **Effective date.** Hospitals participating in the medicare swing bed program on June 25, 1985 shall comply with this section by January 1, 1986, or at the time of the renewal of the medicare swing bed approval, whichever is earlier.

History: *1Sp1985 c 3 s 3*

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 must not provide to patients not reimbursed by medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

History: *1Sp1985 c 3 s 4*

144.658 EPIDEMIOLOGIC DATA DISCOVERY.

Notwithstanding any law to the contrary, health data on an individual collected by public health officials conducting an epidemiologic investigation to reduce morbidity or mortality is not subject to discovery in a legal action.

History: *1985 c 298 s 41*

144.70 BIENNIAL REPORT.

Subdivision 1. **Content.** The commissioner of health shall prepare a report every two years concerning the status and operations of the health care markets in Minnesota. The commissioner of health shall transmit the reports to the governor and to the members of the legislature. The first report must be submitted on January 15, 1987, and succeeding reports on January 15 every two years. Each report must contain information, analysis, and appropriate recommendations concerning the following issues associated with Minnesota health care markets:

(1) the overall status of the health care cost problem, including the costs faced by employers and individuals, and prospects for the problem's improving or getting worse;

(2) the status of competitive forces in the market for health services and the market for health plans, and the effect of the forces on the health care cost problem;

(3) the feasibility and cost-effectiveness of facilitating development of strengthened competitive forces through state initiatives;

(4) the feasibility of limiting health care costs by means other than competitive forces, including direct forms of government intervention such as price regulation; the commissioner of health may exclude this issue from the report if the report concludes that the overall status of the health care cost problem is improving, or that competitive forces are contributing significantly to health care cost containment;

(5) the overall status of access to adequate health services by citizens of Minnesota, the scope of financial and geographic barriers to access, the effect of competitive forces on access, and prospects for access improving or getting worse;

(6) the feasibility and cost-effectiveness of enhancing access to adequate health services by citizens of Minnesota through state initiatives; and

(7) the commissioner of health's operations and activities for the preceding two years as they relate to the duties imposed on the commissioner of health by sections 144.695 to 144.703.

Subd. 2. **Interagency cooperation.** In completing the report required by subdivision 1, in fulfilling the requirements of sections 144.695 to 144.703, and in undertaking other initiatives concerning health care costs, access, or quality, the commissioner of health shall cooperate with and consider potential benefits to other state agencies that have a role in the market for health services or the market for health plans. Other agencies include the department of employee relations, as administrator of the state employee health benefits program; the department of human services, as administrator of health services entitlement programs; the department of commerce, in its regulation of health plans; the department of labor and industry, in its regulation of health service costs under workers' compensation; and the state planning agency, in its planning for the state's health service needs.

History: *1Sp1985 c 9 art 2 s 11*

144.8093 EMERGENCY MEDICAL SERVICES FUND.

Subdivision 1. **Citation.** This section is the "Minnesota emergency medical services system support act."

Subd. 2. **Establishment and purpose.** In order to develop, maintain, and improve regional emergency medical services systems, the department of health shall establish an emergency medical services system fund. The fund shall be used for the general purposes of promoting systematic, cost-effective delivery of emergency medical care throughout the state; identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs; undertaking special projects of statewide significance that will enhance the provision of emergency medical care in Minnesota; providing for public education about emergency medical care; promoting the exchange of emergency medical care information; ensuring the ongoing coordination of regional emergency medical services systems; and establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

Subd. 3. **Use and restrictions.** Designated regional emergency medical services systems may use emergency medical services system funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting and improving emergency trauma and cardiac care and training. No part of a region's share of the fund may be used to directly subsidize any life support transportation service operations or rescue service operations or to purchase any vehicles or parts of vehicles for a life support transportation service or a rescue service.

Subd. 4. **Distribution.** Money from the fund shall be distributed according to this subdivision. Eighty percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the commissioner of health. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations. The commissioner shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions. If one or more of the regions does not contract for the full amount of its even share or if its proposal is unsatisfactory, then the commissioner may reallocate the unused funds to the remaining regions on a pro rata basis. Six and two-thirds percent of the fund shall be used by the commissioner to support regionwide reporting systems and to provide other regional administration and technical assistance. Thirteen and one-third percent shall be distributed by the commissioner as discretionary grants for special emergency medical services projects with potential statewide significance.

History: *1Sp1985 c 9 art 2 s 13*

144.95 MOSQUITO RESEARCH PROGRAM.

Subdivision 1. **Research program.** The commissioner of health shall establish and maintain a long-range program of research to study:

(1) the basic biology, distribution, population ecology, and biosystematics of Minnesota mosquitoes;

(2) the impact of mosquitoes on human and animal health and the economy, including such areas as recreation, tourism, and livestock production;

(3) the baseline population and environmental status of organisms other than mosquitoes that may be affected by mosquito management;

(4) the effects of mosquito management strategies on animals and plants that may result in changes in ecology of specific areas;

(5) the development of mosquito management strategies that are effective, practical, and environmentally safe;

(6) the costs and benefits of development of local and regional management and educational programs.

Subd. 2. **Research facility and field stations.** (a) The commissioner of health shall establish and maintain mosquito management research and development facilities, including but not limited to field research stations in the major mosquito ecologic regions and a center for basic mosquito management research and development. The commissioner shall, to the extent possible, contract with the University of Minnesota in establishing, maintaining, and staffing the research facilities.

(b) The commissioner of health shall establish and implement a program of contractual research grants with public and private agencies and individuals in order to:

(1) undertake supplemental research studies on basic mosquito biology, physiology, and life cycle history beyond those described in subdivision 1;

(2) undertake research into the effects of mosquitoes on human health, including vector-borne diseases, and on animal health, including agricultural and wildlife effects;

(3) undertake studies of other economic factors including tourism and recreation;

(4) collect and analyze baseline data on the ecology and distribution of organisms other than mosquitoes that may be affected as a result of mosquito management strategies;

(5) develop new, effective, practical, and biologically compatible control methods and materials;

(6) conduct additional monitoring of the environmental effects of mosquito control methods and materials;

(7) undertake demonstration, training, and education programs for development of local and regional mosquito management programs.

Subd. 3. **Conduct research trials.** The commissioner of health may develop and conduct research trials of mosquito management methods and materials. Trials may be conducted, with the agreement of the public or private landholder, wherever and whenever the commissioner considers necessary to provide accurate data for determining the efficacy of a method or material in controlling mosquitoes.

Subd. 4. **Research trials.** Research trials of mosquito management methods and materials are subject to the following laws and rules unless a specific written exemption, license, or waiver is granted; sections 97.48, 97.488, 98.48, 105.38, 105.41, and 105.463; and Minnesota Rules, chapters 1505, 6115, 6120, 6134, and 6140.

Subd. 5. **General authority.** (a) To carry out subdivisions 1 to 4, the commissioner of health may:

(1) accept money, property, or services from any source;

(2) receive and hold lands;

(3) accept gifts;

(4) cooperate with city, state, federal, or private agencies whose research on mosquito control or on other environmental matters may be affected by the commissioner's mosquito management and research activities; and

(5) enter into contracts with any public or private entity.

(b) The contracts must specify the duties performed, services provided, and the amount and method of reimbursement for them. Money collected by the commissioner under contracts made under this subdivision is appropriated to the commissioner for the purposes specified in the contracts. Contractual agreements must be processed under section 16B.17.

Subd. 6. **Authority to enter property.** The commissioner of health, officers, employees, or agents may, with express permission of the owner, enter upon any property at reasonable times to:

(1) determine whether mosquito breeding exists;

(2) examine, count, study, or collect laboratory samples to determine the property's geographic, geologic, and biologic characteristics; or

(3) study and collect laboratory samples to determine the effect on animals and vegetation of an insecticide, herbicide, or other method used to control mosquitoes.

Subd. 7. **Research plots.** The commissioner of health may lease and maintain experimental plots of land for mosquito research. The commissioner of health shall determine the locations of the experimental plots and may enter into agreements

with any public or private agency or individual to lease the land. The commissioners of agriculture, natural resources, transportation, iron range resources and rehabilitation, and energy and economic development shall cooperate with the commissioner of health.

Subd. 8. **Emergencies.** The commissioner may suspend or revoke a contract, agreement, or delegated authority granted in this section at any time and without prior notice if an emergency, accident, or hazard threatens the public health.

Subd. 9. **Commissioner required to report.** Each year, the commissioner shall report to the legislature on basic mosquito research findings and progress toward cost-effective, environmentally sound mosquito management methods and materials. The report must recommend future research and management activities.

Subd. 10. **Contingency.** This section is effective only if the tax on cigarettes imposed by United States Code, title 26, section 5701, as amended, is reduced after June 1, 1985, or if other public or private funds sufficient to fund the program are made available to the commissioner for the purposes of this program.

History: *1Sp1985 c 14 art 19 s 17*