SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH SESSION

S.F. No. 2087

(SENATE AUTHORS: SHERAN)

DATE	D-PG	OFFICIAL STATUS
02/27/2014	5895	Introduction and first reading Referred to Health, Human Services and Housing
03/27/2014	6970a	Comm report: To pass as amended
	7055	Second reading
05/07/2014	8843	HF substituted on General Orders HF2402

A bill for an act

relating to health and human services; modifying health care, human services operations, and continuing care provisions; modifying bond requirements for medical suppliers; requiring the commissioner to seek federal authority to amend the state Medicaid plan; modifying the criteria for stroke centers; making changes to home care provider licensing and compliance monitoring; requiring dementia care training; modifying personal care assistance provisions; modifying child care and foster care licensing provisions; amending mental and chemical health provisions; clarifying common entry point related to reports of maltreatment of vulnerable adults; making changes to the local public health system; modifying the licensure requirements for chiropractors, athletic trainers, occupational therapists, licensed professional clinical counselors, podiatry; modifying the certification agencies for doula certification; providing an exception for eyeglass prescription expiration date; requiring employers to report diverted narcotics; regulating electronic cigarettes; exempting certain funeral establishments; exempting dental facilities from diagnostic imaging accreditation; requiring a patient notice with mammogram results; requiring pharmacy benefit mangers to provide maximum allowable cost pricing to pharmacies; prohibiting the use of tanning equipment for children under the age of 18; specifying the protocol for pharmacist administration of vaccines; requiring the commissioner of health to assess and report on the quality of care for ST elevation myocardial infarction; requiring AED devices to be registered with a registry; establishing a health care home advisory committee; authorizing the use of complementary and alternative health care practices; authorizing rulemaking; amending Minnesota Statutes 2012, sections 62J.497, subdivision 5; 144.413, subdivision 4; 144.4165; 144D.065; 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; 148.6402, 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; 151.01, subdivision 27; 153.16, subdivisions 1, 2, 3, by adding subdivisions; 214.33, by adding a subdivision; 245A.02, subdivision 19; 245A.03, subdivision 6a; 253B.092, subdivision 2; 254B.01, by adding a subdivision; 254B.05, subdivision 5; 256B.0654, subdivision 1; 256B.0659,

subdivisions 11, 28; 256B.0751, by adding a subdivision; 256B.493, subdivision 1; 256B.5016, subdivision 1; 256B.69, subdivision 16; 256D.01, subdivision 1e; 256G.02, subdivision 6; 256I.03, subdivision 3; 256I.04, subdivision 2a; 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, by adding a subdivision; Minnesota Statutes 2013 Supplement, sections 103I.205, subdivision 4; 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; 145A.06, subdivision 7; 146A.11, subdivision 1; 245A.1435; 245A.50, subdivision 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.093, subdivision 1; 256B.4912, subdivision 10; 256B.492; 256B.85, subdivision 12; 256D.44, subdivision 5; 260.835, subdivision 2; 626.557, subdivision 9; Laws 2011, First Special Session chapter 9, article 7, section 7; article 9, section 17; Laws 2013, chapter 108, article 7, section 60; proposing coding for new law in Minnesota Statutes, chapters 144; 144D; 145; 146A; 151; 325H; 403; 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; Laws 2011, First Special Session chapter 9, article 6, section 95, subdivisions 1, 2, 3, 4; Minnesota Rules, parts 2500.0100, subparts 3, 4b, 9b; 2500.4000; 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; 9500.1456; 9505.5300; 9505.5305; 9505.5310; 9505.5315; 9505.5325; 9525.1580.

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

ARTICLE 1

HEALTH DEPARTMENT

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. Minnesota Statutes 2013 Supplement, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or section 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal a monitoring well if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must register with the commissioner as a monitoring well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the six activities:

(1) installing or repairing well screens or pitless units or pitless adaptors and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) constructing, repairing, and sealing drive point wells or dug wells;

(3) installing well pumps or pumping equipment;

(4) sealing wells;

(5) constructing, repairing, or sealing dewatering wells; or

(6) constructing, repairing, or sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license or registration, a license or registration is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode; ~~or~~

(2) an individual who performs labor or services for a contractor licensed or registered under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed or registered under the provisions of this chapter; or

(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if the repair location is within an area where there is no licensed or registered well contractor within 25 miles.

Sec. 3. **[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 Mammography Quality Standards Act, United States Code, title 42, section 263b, the following notice:

"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. 4. 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. This section is effective the day following final enactment.

Sec. 5. 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. 6. 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. 7. 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. 8. **[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. 9. 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 documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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 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 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 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 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 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 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. 15. **[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 hours of hire, and two hours of training these topics for each 12 months of employment thereafter.

(c) For managers of establishments not covered by section 325F.72, but who provide assisted living services under chapter 144G, this continuing education must include at least four hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 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.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 16. **[144D.11] EMERGENCY PLANNING.**

(a) Each registered housing with services establishment must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all tenants upon signing a lease;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing tenants.

(b) Each registered housing with services establishment must provide emergency and disaster training to all staff within 30 days of hire and annually thereafter and must make emergency and disaster training available to all tenants annually.

(c) Each registered housing with services location must conduct and document a fire drill or other emergency drill at least every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 17. 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. 18. **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, 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.

ARTICLE 2

PUBLIC HEALTH

Section 1. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 1a. **Areas of public health responsibility.** "Areas of public health responsibility" means:

(1) assuring an adequate local public health infrastructure;

(2) promoting healthy communities and healthy behaviors;

(3) preventing the spread of communicable disease;

(4) protecting against environmental health hazards;

(5) preparing for and responding to emergencies; and

(6) assuring health services.

Sec. 2. Minnesota Statutes 2012, section 145A.02, subdivision 5, is amended to read:

Subd. 5. **Community health board.** "Community health board" means ~~a board of health established, operating, and eligible for a~~ the governing body for local public health ~~grant under sections 145A.09 to 145A.131.~~ in Minnesota. The community health board may be comprised of a single county, multiple contiguous counties, or in a limited number of cases, a single city as specified in section 145A.03, subdivision 1. CHBs have the responsibilities and authority under this chapter.

Sec. 3. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 6a. **Community health services administrator.** "Community health services administrator" means a person who meets personnel standards for the position established under section 145A.06, subdivision 3b, and is working under a written agreement with, employed by, or under contract with a community health board to provide public health leadership and to discharge the administrative and program responsibilities on behalf of the board.

Sec. 4. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 8a. **Local health department.** "Local health department" means an operational entity that is responsible for the administration and implementation of programs and services to address the areas of public health responsibility. It is governed by a community health board.

Sec. 5. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 8b. **Essential public health services.** "Essential public health services" means the public health activities that all communities should undertake. These services serve as the framework for the National Public Health Performance Standards. In Minnesota they refer to activities that are conducted to accomplish the areas of public health responsibility. The ten essential public health services are to:

(1) monitor health status to identify and solve community health problems;

(2) diagnose and investigate health problems and health hazards in the community;

(3) inform, educate, and empower people about health issues;

(4) mobilize community partnerships and action to identify and solve health problems;

(5) develop policies and plans that support individual and community health efforts;

(6) enforce laws and regulations that protect health and ensure safety;

(7) link people to needed personal health services and assure the provision of health care when otherwise unavailable;

(8) maintain a competent public health workforce;

(9) evaluate the effectiveness, accessibility, and quality of personal and population-based health services; and

(10) contribute to research seeking new insights and innovative solutions to health problems.

Sec. 6. Minnesota Statutes 2012, section 145A.02, subdivision 15, is amended to read:

Subd. 15. **Medical consultant.** "Medical consultant" means a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with a community health board ~~of health~~ to provide advice and information, to authorize medical procedures through ~~standing orders~~ protocols, and to assist a community health board ~~of health~~ and its staff in coordinating their activities with local medical practitioners and health care institutions.

Sec. 7. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 15a. **Performance management.** "Performance management" means the systematic process of using data for decision making by identifying outcomes and standards; measuring, monitoring, and communicating progress; and engaging in quality improvement activities in order to achieve desired outcomes.

Sec. 8. Minnesota Statutes 2012, section 145A.02, is amended by adding a subdivision to read:

Subd. 15b. **Performance measures.** "Performance measures" means quantitative ways to define and measure performance.

Sec. 9. Minnesota Statutes 2012, section 145A.03, subdivision 1, is amended to read:

Subdivision 1. **Establishment; assignment of responsibilities.** (a) The governing body of a ~~city or~~ county must undertake the responsibilities of a community health board

~~of health or establish a board of health~~ by establishing or joining a community health board according to paragraphs (b) to (f) and ~~assign~~ assigning to it the powers and duties ~~of a board of health~~ specified under section 145A.04.

(b) ~~A city council may ask a county or joint powers board of health to undertake the responsibilities of a board of health for the city's jurisdiction.~~ A community health board must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.09 to 145A.131 is preempted from forming a ~~board of~~ community health board except as specified in section ~~145A.10, subdivision 2~~ 145A.131.

(d) A county board or a joint powers board that establishes a community health board and has or establishes an operational human services board under chapter 402 may assign the powers and duties of a community health board to a human services board. Eligibility for funding from the commissioner will be maintained if all requirements of sections 145A.03 and 145A.04 are met.

(e) Community health boards established prior to January 1, 2014, including city community health boards, are eligible to maintain their status as community health boards as outlined in this subdivision.

(f) A community health board may authorize, by resolution, the community health service administrator or other designated agent or agents to act on behalf of the community health board.

Sec. 10. Minnesota Statutes 2012, section 145A.03, subdivision 2, is amended to read:

Subd. 2. **Joint powers community health board ~~of health.~~** ~~Except as preempted under section 145A.10, subdivision 2,~~ A county may establish a joint community health board ~~of health~~ by agreement with one or more contiguous counties, or ~~a~~ an existing city community health board may establish a joint community health board ~~of health~~ with one or more contiguous ~~cities in the same county, or a city may establish a joint board of health with the~~ existing city community health boards in the same county ~~or counties within~~ in which it is located. The agreements must be established according to section 471.59.

Sec. 11. Minnesota Statutes 2012, section 145A.03, subdivision 4, is amended to read:

Subd. 4. **Membership; duties of chair.** A community health board ~~of health~~ must have at least five members, one of whom must be elected by the members as chair and one as vice-chair. The chair, or in the chair's absence, the vice-chair, must preside at meetings

of the community health board ~~of health~~ and sign or authorize an agent to sign contracts and other documents requiring signature on behalf of the community health board ~~of health~~.

Sec. 12. Minnesota Statutes 2012, section 145A.03, subdivision 5, is amended to read:

Subd. 5. **Meetings.** A community health board ~~of health~~ must hold meetings at least twice a year and as determined by its rules of procedure. The board must adopt written procedures for transacting business and must keep a public record of its transactions, findings, and determinations. Members may receive a per diem plus travel and other eligible expenses while engaged in official duties.

Sec. 13. Minnesota Statutes 2012, section 145A.03, is amended by adding a subdivision to read:

Subd. 7. **Community health board; eligibility for funding.** A community health board that meets the requirements of this section is eligible to receive the local public health grant under section 145A.131 and for other funds that the commissioner grants to community health boards to carry out public health activities.

Sec. 14. Minnesota Statutes 2012, section 145A.04, as amended by Laws 2013, chapter 43, section 21, is amended to read:

145A.04 POWERS AND DUTIES OF COMMUNITY HEALTH BOARD ~~OF HEALTH~~.

Subdivision 1. **Jurisdiction; enforcement.** (a) A ~~county or multicounty~~ community health board ~~of health~~ has the ~~powers and duties of a board of health for all territory within its jurisdiction not under the jurisdiction of a city board of health. Under the general supervision of the commissioner, the board shall enforce laws, regulations, and ordinances pertaining to the powers and duties of a board of health within its jurisdictional area~~ general responsibility for development and maintenance of a system of community health services under local administration and within a system of state guidelines and standards.

(b) Under the general supervision of the commissioner, the community health board shall recommend the enforcement of laws, regulations, and ordinances pertaining to the powers and duties within its jurisdictional area. In the case of a multicounty or city community health board, the joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07 shall clearly specify enforcement authorities.

(c) A member of a community health board may not withdraw from a joint powers community health board during the first two calendar years following the effective

date of the initial joint powers agreement. The withdrawing member must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

(d) The withdrawal of a county or city from a community health board does not 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;

(2) submit to the commissioner of health, at least every five years, a community health assessment and community health improvement plan, which shall be developed with input from the community and take into consideration the statewide outcomes, the areas of responsibility, and essential public health services;

(3) implement a performance management process in order to achieve desired outcomes; and

(4) annually report to the commissioner on a set of performance measures and be prepared to provide documentation of ability to meet the performance measures.

Subd. 2. **Appointment of ~~agent~~ community health service (CHS) administrator.** A community health board ~~of health~~ must appoint, employ, or contract with a ~~person or persons~~ CHS administrator to act on its behalf. The board shall notify the commissioner of the ~~agent's name, address, and phone number where the agent may be reached between board meetings~~ CHS administrator's contact information and submit a copy of the resolution authorizing the ~~agent~~ CHS administrator to act as an agent on the board's behalf. The resolution must specify the types of action or actions that the CHS administrator is authorized to take on behalf of the board.

Subd. 2a. **Appointment of medical consultant.** The community health board shall appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the community health board and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 3. **Employment; ~~medical consultant~~ employees.** (a) A community health board ~~of health may establish a health department or other administrative agency and~~ may employ persons as necessary to carry out its duties.

(b) Except where prohibited by law, employees of the community health board ~~of health~~ may act as its agents.

(c) ~~Employees of the board of health are subject to any personnel administration rules adopted by a city council or county board forming the board of health unless the employees of the board are within the scope of a statewide personnel administration system.~~ Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights.

~~(d) The board of health may appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.~~

Subd. 4. **Acquisition of property; request for and acceptance of funds; collection of fees.** (a) A community health board ~~of health~~ may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to 145A.131. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

(b) A community health board ~~of health~~ may accept gifts, grants, and subsidies from any lawful source, apply for and accept state and federal funds, and request and accept local tax funds.

(c) A community health board ~~of health~~ may establish and collect reasonable fees for performing its duties and providing community health services.

(d) With the exception of licensing and inspection activities, access to community health services provided by or on contract with the community health board ~~of health~~ must not be denied to an individual or family because of inability to pay.

Subd. 5. **Contracts.** To improve efficiency, quality, and effectiveness, avoid unnecessary duplication, and gain cost advantages, a community health board ~~of health~~ may contract to provide, receive, or ensure provision of services.

Subd. 6. **Investigation; reporting and control of communicable diseases.** A community health board ~~of health~~ shall make investigations, or coordinate with any county board or city council within its jurisdiction to make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Community health boards ~~of health~~ must cooperate so far as practicable to act together to prevent and control epidemic diseases.

Subd. 6a. **Minnesota Responds Medical Reserve Corps; planning.** A community health board ~~of health~~ receiving funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services shall participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of the

Department of Health. A community health board ~~of health~~ shall collaborate on volunteer planning with other public and private partners, including but not limited to local or regional health care providers, emergency medical services, hospitals, tribal governments, state and local emergency management, and local disaster relief organizations.

Subd. 6b. **Minnesota Responds Medical Reserve Corps; agreements.** A community health board ~~of health~~, county, or city participating in the Minnesota Responds Medical Reserve Corps program may enter into written mutual aid agreements for deployment of its paid employees and its Minnesota Responds Medical Reserve Corps volunteers with other community health boards ~~of health~~, other political subdivisions within the state, or with tribal governments within the state. A community health board ~~of health~~ may also enter into agreements with the Indian Health Services of the United States Department of Health and Human Services, and with boards of health, political subdivisions, and tribal governments in bordering states and Canadian provinces.

Subd. 6c. **Minnesota Responds Medical Reserve Corps; when mobilized.** When a community health board ~~of health~~, county, or city finds that the prevention, mitigation, response to, or recovery from an actual or threatened public health event or emergency exceeds its local capacity, it shall use available mutual aid agreements. If the event or emergency exceeds mutual aid capacities, a community health board ~~of health~~, county, or city may request the commissioner of health to mobilize Minnesota Responds Medical Reserve Corps volunteers from outside the jurisdiction of the community health board ~~of health~~, county, or city.

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

Subd. 7. **Entry for inspection.** To enforce public health laws, ordinances or rules, a member or agent of a community health board ~~of health~~, county, or city may enter a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected.

Subd. 8. **Removal and abatement of public health nuisances.** (a) If a threat to the public health such as a public health nuisance, source of filth, or cause of sickness is found on any property, the community health board ~~of health~~, county, city, or its agent shall order the owner or occupant of the property to remove or abate the threat within a time specified in the notice but not longer than ten days. Action to recover costs of enforcement under this subdivision must be taken as prescribed in section 145A.08.

(b) Notice for abatement or removal must be served on the owner, occupant, or agent of the property in one of the following ways:

(1) by registered or certified mail;

(2) by an officer authorized to serve a warrant; or

(3) by a person aged 18 years or older who is not reasonably believed to be a party to any action arising from the notice.

(c) If the owner of the property is unknown or absent and has no known representative upon whom notice can be served, the community health board ~~of health~~, county, or city, or its agent, shall post a written or printed notice on the property stating that, unless the threat to the public health is abated or removed within a period not longer than ten days, the community health board, county, or city will have the threat abated or removed at the expense of the owner under section 145A.08 or other applicable state or local law.

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the community health board ~~of health~~, county, city, or ~~its~~ a designated agent of the board, county, or city shall remove or abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the community health board ~~of health~~, county, or city may bring an action in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

Subd. 10. **Hindrance of enforcement prohibited; penalty.** It is a misdemeanor ~~deliberately~~ to deliberately hinder a member of a community health board ~~of health~~, county or city, or its agent from entering a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected, or otherwise to interfere with the performance of the duties of the ~~board of health~~ responsible jurisdiction.

Subd. 11. **Neglect of enforcement prohibited; penalty.** It is a misdemeanor for a member or agent of a community health board ~~of health~~, county, or city to refuse or neglect to perform a duty imposed on ~~a board of health~~ an applicable jurisdiction by statute or ordinance.

Subd. 12. **Other powers and duties established by law.** This section does not limit powers and duties of a community health board ~~of health~~, county, or city prescribed in other sections.

Subd. 13. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 14. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 15. **State and local advisory committees.** (a) A state community health services advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of local public health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) Notwithstanding section 15.059, the State Community Health Services Advisory Committee does not expire.

(c) The city boards or county boards that have established or are members of a community health board may appoint a community health advisory to advise, consult with, and make recommendations to the community health board on the duties under subdivision 1a.

Sec. 15. Minnesota Statutes 2012, section 145A.05, subdivision 2, is amended to read:

Subd. 2. **Animal control.** In addition to powers under sections 35.67 to 35.69, a county board, city council, or municipality may adopt ordinances to issue licenses or otherwise regulate the keeping of animals, to restrain animals from running at large, to authorize the impounding and sale or summary destruction of animals, and to establish pounds.

Sec. 16. Minnesota Statutes 2012, section 145A.06, subdivision 2, is amended to read:

Subd. 2. **Supervision of local enforcement.** (a) In the absence of provision for a community health board ~~of health~~, the commissioner may appoint three or more persons to act as a board until one is established. The commissioner may fix their compensation, which the county or city must pay.

(b) The commissioner by written order may require any two or more community health boards ~~of health~~, counties, or cities to act together to prevent or control epidemic diseases.

(c) If a community health board, county, or city fails to comply with section 145A.04, subdivision 6, the commissioner may employ medical and other help necessary to control communicable disease at the expense of the ~~board of health~~ jurisdiction involved.

(d) If the commissioner has reason to believe that the provisions of this chapter have been violated, the commissioner shall inform the attorney general and submit information to support the belief. The attorney general shall institute proceedings to enforce the provisions of this chapter or shall direct the county attorney to institute proceedings.

Sec. 17. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 3a. **Assistance to community health boards.** The commissioner shall help and advise community health boards that ask for assistance in developing, administering, and carrying out public health services and programs. This assistance may consist of, but is not limited to:

(1) informational resources, consultation, and training to assist community health boards plan, develop, integrate, provide, and evaluate community health services; and

(2) administrative and program guidelines and standards developed with the advice of the State Community Health Services Advisory Committee.

Sec. 18. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 3b. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Services Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Sec. 19. Minnesota Statutes 2012, section 145A.06, subdivision 5, is amended to read:

Subd. 5. **Deadly infectious diseases.** The commissioner shall promote measures aimed at preventing businesses from facilitating sexual practices that transmit deadly infectious diseases by providing technical advice to community health boards ~~of health~~ to assist them in regulating these practices or closing establishments that constitute a public health nuisance.

Sec. 20. Minnesota Statutes 2012, section 145A.06, is amended by adding a subdivision to read:

Subd. 5a. **System-level performance management.** To improve public health and ensure the integrity and accountability of the statewide local public health system, the commissioner, in consultation with the State Community Health Services Advisory Committee, shall develop performance measures and implement a process to monitor statewide outcomes and performance improvement.

Sec. 21. Minnesota Statutes 2012, section 145A.06, subdivision 6, is amended to read:

Subd. 6. **Health volunteer program.** (a) The commissioner may accept grants from the United States Department of Health and Human Services for the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b. The ESAR-VHP program as implemented in Minnesota is known as the Minnesota Responds Medical Reserve Corps.

(b) The commissioner may maintain a registry of volunteers for the Minnesota Responds Medical Reserve Corps and obtain data on volunteers relevant to possible deployments within and outside the state. All state licensing and certifying boards shall cooperate with the Minnesota Responds Medical Reserve Corps and shall verify volunteers' information. The commissioner may also obtain information from other states and national licensing or certifying boards for health practitioners.

(c) The commissioner may share volunteers' data, including any data classified as private data, from the Minnesota Responds Medical Reserve Corps registry with community health boards ~~of health~~, cities or counties, the University of Minnesota's Academic Health Center or other public or private emergency preparedness partners, or tribal governments operating Minnesota Responds Medical Reserve Corps units as needed for credentialing, organizing, training, and deploying volunteers. Upon request of another state participating in the ESAR-VHP or of a Canadian government administering a similar health volunteer program, the commissioner may also share the volunteers' data as needed for emergency preparedness and response.

Sec. 22. Minnesota Statutes 2013 Supplement, section 145A.06, subdivision 7, is amended to read:

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

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

(2) the University of Minnesota Academic Health Center;

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

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

(5) a tribal or Canadian government;

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

(b) The commissioner may request Minnesota Responds Medical Reserve Corps volunteers to work on the Minnesota Mobile Medical Unit (MMU), or on other mobile or temporary units providing emergency patient stabilization, medical transport, or ambulatory care. The commissioner may utilize the volunteers for training, mobilization or demobilization, inspection, maintenance, repair, or other support functions for the MMU facility or for other emergency units, as well as for provision of health care services.

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

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2012, section 145A.07, subdivision 1, is amended to read:

Subdivision 1. **Agreements to perform duties of commissioner.** (a) The commissioner of health may enter into an agreement with any community health board ~~of health~~, county, or city to delegate all or part of the licensing, inspection, reporting, and

enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

(c) This subdivision does not affect agreements entered into under Minnesota Statutes 1986, section 145.031, 145.55, or 145.918, subdivision 2.

Sec. 24. Minnesota Statutes 2012, section 145A.07, subdivision 2, is amended to read:

Subd. 2. **Agreements to perform duties of community health board ~~of health~~.** A community health board ~~of health~~ may authorize a ~~township board,~~ city ~~council,~~ or county ~~board~~ within its jurisdiction to ~~establish a board of health under section 145A.03 and delegate to the board of health by agreement any powers or duties under sections 145A.04, 145A.07, subdivision 2, and 145A.08~~ carry out activities to fulfill community health board responsibilities. An agreement to delegate community health board powers and duties ~~of a board of health~~ to a county or city must be approved by the commissioner ~~and is subject to subdivision 3~~.

Sec. 25. Minnesota Statutes 2012, section 145A.08, is amended to read:

145A.08 ASSESSMENT OF COSTS; TAX LEVY AUTHORIZED.

Subdivision 1. **Cost of care.** A person who has or whose dependent or spouse has a communicable disease that is subject to control by the community health board ~~of health~~ is financially liable to the unit or agency of government that paid for the reasonable cost of care provided to control the disease under section 145A.04, subdivision 6.

Subd. 2. **Assessment of costs of enforcement.** (a) If costs are assessed for enforcement of section 145A.04, subdivision 8, and no procedure for the assessment of costs has been specified in an agreement established under section 145A.07, the enforcement costs must be assessed as prescribed in this subdivision.

(b) A debt or claim against an individual owner or single piece of real property resulting from an enforcement action authorized by section 145A.04, subdivision 8, must not exceed the cost of abatement or removal.

(c) The cost of an enforcement action under section 145A.04, subdivision 8, may be assessed and charged against the real property on which the public health nuisance, source of filth, or cause of sickness was located. The auditor of the county in which the action is taken shall extend the cost so assessed and charged on the tax roll of the county against the real property on which the enforcement action was taken.

(d) The cost of an enforcement action taken by a town or city ~~board of health~~ under section 145A.04, subdivision 8, may be recovered from the county in which the town or city is located if the city clerk or other officer certifies the costs of the enforcement action to the county auditor as prescribed in this section. Taxes equal to the full amount of the enforcement action but not exceeding the limit in paragraph (b) must be collected by the county treasurer and paid to the city or town as other taxes are collected and paid.

Subd. 3. **Tax levy authorized.** A city council or county board that has formed or is a member of a community health board ~~of health~~ may levy taxes on all taxable property in its jurisdiction to pay the cost of performing its duties under this chapter.

Sec. 26. Minnesota Statutes 2012, section 145A.11, subdivision 2, is amended to read:

Subd. 2. **Levying taxes.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet local public health priorities established under section ~~145A.10, subdivision 5a~~ 145A.04, subdivision 1a, clause (2), and statewide outcomes ~~established~~ under section ~~145A.12, subdivision 7~~ 145A.04, subdivision 1a, clause (1).

Sec. 27. Minnesota Statutes 2012, section 145A.131, is amended to read:

145A.131 LOCAL PUBLIC HEALTH GRANT.

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section ~~145A.09, subdivision 2~~ 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section ~~145A.09, subdivision 2~~ 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections ~~145A.09~~ 145A.03 to 145A.131 to achieve locally identified priorities under section ~~145A.12, subdivision 7, by July 1, 2004~~ 145A.04, subdivision 1a, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to (d).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections ~~145A.09~~ 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Accountability.** (a) Community health boards accepting local public health grants must ~~document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.~~ meet all of the requirements and perform all of the duties described in sections 145A.03 and 145A.04, to maintain eligibility to receive the local public health grant.

~~(b) In determining whether or not the community health board is documenting progress toward statewide outcomes, the commissioner shall consider the following factors:~~

~~(1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;~~

~~(2) the effort put forth by the community health board toward the selected statewide outcomes;~~

~~(3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;~~

~~(4) the amount of funding received by the community health board to address the statewide outcomes; and~~

~~(5) other factors as the commissioner may require, if the commissioner specifically identifies the additional factors in the commissioner's written notice of determination.~~

~~(c) If the commissioner determines that a community health board has not by the applicable deadline documented progress toward the selected statewide outcomes established under section 145.8821 or 145A.12, subdivision 7, the commissioner shall notify the community health board in writing and recommend specific actions that the community health board should take over the following 12 months to maintain eligibility for the local public health grant.~~

~~(d) During the 12 months following the written notification, the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in the written notification.~~

~~(e) If the community health board has not taken the specific actions recommended by the commissioner within 12 months following written notification, the commissioner may determine not to distribute funds to the community health board under section 145A.12, subdivision 2, for the next fiscal year.~~

~~(f) If the commissioner determines not to distribute funds for the next fiscal year, the commissioner must give the community health board written notice of this determination and allow the community health board to appeal the determination in writing.~~

~~(g) If the commissioner determines not to distribute funds for the next fiscal year to a community health board that has not documented progress toward the statewide outcomes and not taken the actions recommended by the commissioner, the commissioner may retain local public health grant funds that the community health board would have otherwise received and directly carry out essential local activities to meet the statewide outcomes, or contract with other units of government or community-based organizations to carry out essential local activities related to the statewide outcomes.~~

~~(h) If the community health board that does not document progress toward the statewide outcomes is a city, the commissioner shall distribute the local public health funds that would have been allocated to that city to the county in which the city is located, if that county is part of a community health board.~~

~~(i) The commissioner shall establish a reporting system by which community health boards will document their progress toward statewide outcomes. This system will be developed in consultation with the State Community Health Services Advisory Committee established in section 145A.10, subdivision 10, paragraph (a).~~

(b) By January 1 of each year, the commissioner shall notify community health boards of the performance-related accountability requirements of the local public health grant for that calendar year. Performance-related accountability requirements will be

comprised of a subset of the annual performance measures and will be selected in consultation with the State Community Health Services Advisory Committee.

(c) If the commissioner determines that a community health board has not met the accountability requirements, the commissioner shall notify the community health board in writing and recommend specific actions the community health board must take over the next six months in order to maintain eligibility for the Local Public Health Act grant.

(d) Following the written notification in paragraph (c), the commissioner shall provide administrative and program support to assist the community health board as required in section 145A.06, subdivision 3a.

(e) The commissioner shall provide the community health board two months following the written notification to appeal the determination in writing.

(f) If the community health board has not submitted an appeal within two months or has not taken the specific actions recommended by the commissioner within six months following written notification, the commissioner may elect to not reimburse invoices for funds submitted after the six-month compliance period and shall reduce by 1/12 the community health board's annual award allocation for every successive month of noncompliance.

(g) The commissioner may retain the amount of funding that would have been allocated to the community health board and assume responsibility for public health activities in the geographic area served by the community health board.

Subd. 4. **Responsibility of commissioner to ensure a statewide public health system.** ~~If a county withdraws from a community health board and operates as a board of health or~~ If a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board ~~using the formula described in subdivision 1~~ and assume responsibility for public health activities ~~to meet the statewide outcomes~~ in the geographic area served ~~by the board of health or community health board~~. The commissioner may elect to directly provide public health activities ~~to meet the statewide outcomes~~ or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located~~, if the county is part of a community health board~~.

Subd. 5. ~~**Local public health priorities**~~ **Use of funds.** Community health boards may use their local public health grant ~~to address local public health priorities identified under section 145A.10, subdivision 5a.~~ funds to address the areas of public health

responsibility and local priorities developed through the community health assessment and community health improvement planning process.

Sec. 28. **REVISOR'S INSTRUCTION.**

(a) The revisor shall change the terms "board of health" or "local board of health" or any derivative of those terms to "community health board" where it appears in Minnesota Statutes, sections 13.3805, subdivision 1, paragraph (b); 13.46, subdivision 2, paragraph (a), clause (24); 35.67; 35.68; 38.02, subdivision 1, paragraph (b), clause (1); 121A.15, subdivisions 7 and 8; 144.055, subdivision 1; 144.065; 144.12, subdivision 1; 144.225, subdivision 2a; 144.3351; 144.383; 144.417, subdivision 3; 144.4172, subdivision 6; 144.4173, subdivision 2; 144.4174; 144.49, subdivision 1; 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 3

HEALTH CARE

Section 1. Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial

enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid

Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, ~~the provider agency~~ durable medical equipment providers and suppliers defined in clause (3) must purchase a ~~performance~~ surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a ~~performance~~ surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a ~~performance~~ surety bond of $100,000. The ~~performance~~ surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a ~~performance~~ surety bond as a condition of initial enrollment, reenrollment, reinstatement,

or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The ~~performance~~ surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The ~~performance~~ surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 2. 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. 3. Minnesota Statutes 2012, section 256B.0751, is amended by adding a subdivision to read:

Subd. 10. **Health care homes advisory committee.** (a) The commissioners of health and human services shall establish a health care homes advisory committee to advise the commissioners on the ongoing statewide implementation of the health care homes program authorized in section 256B.072.

(b) The commissioners shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; nursing

and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes.

(c) The advisory committee shall advise the commissioners on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care home evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care home rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care home subject matter task forces or workgroups; and

(7) other related issues as requested by the commissioners.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 16, is amended to read:

Subd. 16. **Project extension.** Minnesota Rules, parts 9500.1450; 9500.1451; 9500.1452; 9500.1453; 9500.1454; 9500.1455; ~~9500.1456;~~ 9500.1457; 9500.1458; 9500.1459; 9500.1460; 9500.1461; 9500.1462; 9500.1463; and 9500.1464 are extended.

Sec. 5. **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. 6. **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. 7. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall remove cross-references to the sections and parts repealed in section 8, 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 meanings.

Sec. 8. **REPEALER.**

(a) Minnesota Rules, parts 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; and 9500.1456, are repealed.

(b) 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 6. The commissioner of human services shall notify the revisor of statutes when this occurs.

ARTICLE 4

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 256B.0654, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) "Complex ~~private duty~~ home care nursing ~~care~~" means home care nursing services provided to recipients who ~~are ventilator dependent or for whom a physician has certified that the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care~~ meet the criteria for regular home care nursing and require life-sustaining interventions to reduce the risk of long-term injury or death.

(b) "~~Private duty~~ Home care nursing" means ongoing ~~professional~~ physician-ordered hourly nursing services ~~by a registered or licensed practical nurse including assessment, professional nursing tasks, and education, based on an assessment and physician orders to maintain or restore optimal health of the recipient.~~ performed by a registered nurse or

licensed practical nurse within the scope of practice as defined by the Minnesota Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a person's health.

(c) "~~Private duty~~ Home care nursing agency" means a medical assistance enrolled provider licensed under chapter 144A to provide ~~private duty~~ home care nursing services.

(d) "Regular ~~private duty~~ home care nursing" means ~~nursing services provided to a recipient who is considered stable and not at an inpatient hospital intensive care unit level of care, but may have episodes of instability that are not life threatening.~~ home care nursing provided because:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(e) "Shared ~~private duty~~ home care nursing" means the provision of home care nursing services by a ~~private duty~~ home care nurse to two recipients at the same time and in the same setting.

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

Sec. 2. Minnesota Statutes 2012, section 256B.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. 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.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. 5. 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 reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 6. Minnesota Statutes 2013 Supplement, section 256B.4912, subdivision 10, is amended to read:

Subd. 10. **Enrollment requirements.** ~~All~~ (a) Except as provided in paragraph (b), the following home and community-based waiver providers must provide, at the time of enrollment and within 30 days of a request, in a format determined by the commissioner, information and documentation that includes~~, but is not limited to, the following:~~

~~(1) proof of surety bond coverage in the amount of $50,000 or ten percent of the provider's payments from Medicaid in the previous calendar year, whichever is greater;~~

~~(2) proof of fidelity bond coverage in the amount of $20,000; and~~

~~(3)~~ proof of liability insurance~~.~~:

(1) waiver services providers required to meet the provider standards in chapter 245D;

(2) foster care providers whose services are funded by the elderly waiver or alternative care program;

(3) fiscal support entities;

(4) adult day care providers;

(5) providers of customized living services; and

(6) residential care providers.

(b) Providers of foster care services covered by section 245.814 are exempt from this subdivision.

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

Sec. 7. 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. 8. 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. Minnesota Statutes 2012, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required.** A county agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a residential care home; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; ~~or~~ (iii) a residence licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed by the commissioner of human services under chapter 245D;

(3) the establishment is registered under chapter 144D and provides three meals a day, or is an establishment voluntarily registered under section 144D.025 as a supportive housing establishment; or

(4) an establishment voluntarily registered under section 144D.025, other than a supportive housing establishment under clause (3), is not eligible to provide group residential housing.

The requirements under clauses (1) to (4) do not apply to establishments exempt from state licensure because they are located on Indian reservations and subject to tribal health and safety requirements.

Sec. 16. 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. 17. 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. 18. Laws 2013, chapter 108, article 7, section 60, is amended to read:

Sec. 60. **PROVIDER RATE AND GRANT INCREASE EFFECTIVE APRIL 1, 2014.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by one percent for the rate period beginning April 1, 2014, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

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

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

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

(5) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service, formerly funded under Minnesota Statutes 2010, chapter 256M;

(10) alternative care services under Minnesota Statutes, section 256B.0913, and essential community supports under Minnesota Statutes, section 256B.0922;

(11) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256M;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) housing access grants under Minnesota Statutes, sections 256B.0658 and 256B.0917, subdivision 14;

(16) self-advocacy grants under Laws 2009, chapter 101;

(17) technology grants under Laws 2009, chapter 79;

(18) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928; and

(19) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9; and Laws 1997, First Special Session chapter 5, section 20.

(c) A managed care plan receiving state payments for the services in this section must include these increases in their payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the specified services for the period beginning April 1, 2014.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

EFFECTIVE DATE. This section is effective April 1, 2014.

Sec. 19. **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.

Sec. 20. **REPEALER.**

Minnesota Rules, part 9525.1580, is repealed.

ARTICLE 5

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.

(e) A license holder must be able to show a safe sleep space readily available for each infant present in the license holder's care. Each safe sleep space must meet the requirements of this subdivision.

Sec. 3. 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 instructed 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 these trainings, 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. 4. 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. 5. 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. 6. 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. 7. 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; and

(2) a motor vehicle in which a foster child is transported.

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

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

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

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

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

Sec. 8. Minnesota Statutes 2012, section 626.556, is amended by adding a subdivision to read:

Subd. 7a. **Mandatory guidance for screening reports.** Child protection intake workers, supervisors, and others involved with child protection screening shall follow the guidance provided in the Department of Human Services Minnesota Child Maltreatment Screening Guidelines when screening maltreatment referrals, and, when notified by the commissioner of human services, shall immediately implement updated procedures and protocols.

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

Sec. 9. 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.

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

ARTICLE 6

HEALTH-RELATED 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 complimentary 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, 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 148.6402, 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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. 21. 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 (CAPPA), Childbirth International, ~~or~~ the International Center for Traditional Childbearing, or Commonsense Childbirth, Inc.

Sec. 22. 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. 23. 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. 24. 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) has a license that is active and in good standing;

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

(4) 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;

(5) 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;

(6) 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;

(7) 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

(8) 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. 25. Minnesota Statutes 2012, section 151.01, subdivision 27, is amended to read:

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

(1) interpretation and evaluation of prescription drug orders;

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

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

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

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

(i) the protocol includes, at a minimum:

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

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

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

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

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

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

(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 (ACIP), 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 prescription 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 prescription drug order is consistent with United States Food and Drug Administration-approved labeling of the vaccine;

(6) participation in the practice of managing drug therapy and modifying drug therapy, according to section 151.21, subdivision 1, according to a written protocol

between the specific pharmacist and the individual dentist, optometrist, physician, podiatrist, or veterinarian who is responsible for the patient's care and authorized to independently prescribe drugs. Any significant changes in drug therapy must be reported by the pharmacist to the patient's medical record;

(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.

Sec. 26. 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. 27. 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. 28. 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. 29. 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. 30. Minnesota Statutes 2012, section 153.16, is amended by adding a subdivision to read:

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

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

Sec. 31. 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 patient is regulated by the health-related licensing board; 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.

(c) Complying with subdivision 1 does not waive the requirement to report under this subdivision.

Sec. 32. **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.

(c) Minnesota Rules, parts 2500.0100, subparts 3, 4b, and 9b; and 2500.4000, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective the day following final enactment.

ARTICLE 7

CHEMICAL AND MENTAL HEALTH

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

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

(b) The requirements for certification are:

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

(i) mental health diagnoses;

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

(iii) recovery from mental illness;

(iv) treatment options including evidence-based practices;

(v) medications and their side effects;

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

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

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

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

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

(4) there is a crisis plan for each ~~individual's Individual Placement Agreement~~ individual that identifies who is providing clinical services and their contact information,

and includes an individual crisis prevention and management plan developed with the individual.

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

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

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

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

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

245D.33 ADULT MENTAL HEALTH CERTIFICATION STANDARDS.

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

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

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

~~(i) mental health diagnoses;~~

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

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

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

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

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

~~(vii) community resources;~~

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

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

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

~~(c)~~ (b) 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 2012, section 254B.01, is amended by adding a subdivision to read:

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

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

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

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

Sec. 5. 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. 6. **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 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 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 8

MISCELLANEOUS

Section 1. Minnesota Statutes 2012, section 144.413, subdivision 4, is amended to read:

Subd. 4. **Smoking.** "Smoking" means inhaling or exhaling smoke or vapor from any lighted or heated cigar, cigarette, pipe, or any other lighted or heated tobacco or plant product or electronic delivery device, as defined in section 609.685. Smoking also

includes ~~carrying~~ holding a lighted or heated cigar, cigarette, pipe, or any other lighted or heated tobacco or plant product or electronic delivery device intended for inhalation.

Sec. 2. Minnesota Statutes 2012, section 144.4165, is amended to read:

144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product, or inhale or exhale vapor from an electronic delivery device, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755 subdivision 12.

Sec. 3. **[145.7131] EXCEPTION TO EYEGLASS PRESCRIPTION EXPIRATION.**

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

(b) A person may elect to use an eyeglass prescription from an expired prescription if the person has been advised by an optician, optometrist, physician, or eyeglass retailer on the risks involved with using an expired prescription.

Sec. 4. **[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. 5. 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. Notwithstanding section 15.059, subdivision 5, the council ~~expires June 30, 2014~~ does not expire.

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

Sec. 6. 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. Notwithstanding section 15.059, subdivision 5, the council ~~expires June 30, 2014~~ does not expire. 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. 7. Minnesota Statutes 2013 Supplement, section 256B.093, subdivision 1, is amended to read:

Subdivision 1. **State traumatic brain injury program.** (a) The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with brain injuries;

(5) investigate the need for the development of rules or statutes for the brain injury home and community-based services waiver; and

(6) investigate present and potential models of service coordination which can be delivered at the local level~~; and~~.

~~(7)~~ (b) The advisory committee required by paragraph (a), clause (4), must consist of no fewer than ten members and no more than 30 members. The commissioner shall appoint all advisory committee members to one- or two-year terms and appoint one member as chair. Notwithstanding section 15.059, subdivision 5, the advisory committee does not ~~terminate until June 30, 2014~~ expire.

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

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~~ does not expire.

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

Sec. 9. 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. 10. **[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. 11. 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 and shall be subject to a penalty of not less than $150 for the first violation and not more than $300 for each subsequent violation.

Sec. 12. 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. 13. 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 (b).

Sec. 14. **[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) "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.

(e) "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.

(f) "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.

(g) "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.

(h) "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 or criminal 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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. 21. **REPEALER.**

(a) Minnesota Statutes 2012, section 256.01, subdivision 32, is repealed.

(b) Minnesota Statutes 2012, sections 325H.06; and 325H.08, are repealed.

(c) Laws 2011, First Special Session chapter 9, article 6, section 95, subdivisions 1, 2, 3, and 4, are repealed.

APPENDIX
Article locations in S2087-1

ARTICLE 1	HEALTH DEPARTMENT	Page.Ln 2.28
ARTICLE 2	PUBLIC HEALTH	Page.Ln 14.25
ARTICLE 3	HEALTH CARE	Page.Ln 34.27
ARTICLE 4	CONTINUING CARE	Page.Ln 40.20
ARTICLE 5	CHILDREN AND FAMILIES	Page.Ln 59.8
ARTICLE 6	HEALTH-RELATED BOARDS	Page.Ln 66.31
ARTICLE 7	CHEMICAL AND MENTAL HEALTH	Page.Ln 85.4
ARTICLE 8	MISCELLANEOUS	Page.Ln 90.28

145A.02 DEFINITIONS.

Subd. 2. **Board of health.** "Board of health" or "board" means an administrative authority established under section 145A.03 or 145A.07.

145A.03 ESTABLISHMENT AND ORGANIZATION.

Subd. 3. **Withdrawal from joint powers board of health.** A county or city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

Subd. 6. **Duplicate licensing.** A local board of health must work with the commissioner of agriculture to eliminate duplicate licensing and inspection of grocery and convenience stores by no later than March 1, 1992.

145A.09 PURPOSE; FORMATION; ELIGIBILITY; WITHDRAWAL.

Subdivision 1. **General purpose.** The purpose of sections 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Subd. 2. **Community health board; eligibility.** A board of health that meets the requirements of sections 145A.09 to 145A.131 is a community health board and is eligible for a local public health grant under section 145A.131.

Subd. 3. **Population requirement.** A board of health must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties to be eligible to form a community health board.

Subd. 4. **Cities.** A city that meets the requirements of sections 145A.09 to 145A.131 is eligible for a local public health grant under section 145A.131.

Subd. 5. **Human services board.** A county board or a joint powers board of health that establishes a community health board and has or establishes an operational human services board under chapter 402 must assign the powers and duties of a community health board to the human services board.

Subd. 7. **Withdrawal.** (a) A county or city that has established or joined a community health board may withdraw from the local public health grant program authorized by sections 145A.09 to 145A.131 by resolution of its governing body in accordance with section 145A.03, subdivision 3, and this subdivision.

(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

(c) The withdrawal of a county or city from a community health board does not affect the eligibility for the local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(d) The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

145A.10 POWERS AND DUTIES OF COMMUNITY HEALTH BOARDS.

Subdivision 1. **General.** A community health board has the powers and duties of a board of health prescribed in sections 145A.03, 145A.04, 145A.07, and 145A.08, as well as the general responsibility for development and maintenance of an integrated system of community health services as prescribed in sections 145A.09 to 145A.131.

Subd. 2. **Preemption.** (a) Not later than 365 days after the formation of a community health board, any other board of health within the community health service area for which the plan has been prepared must cease operation, except as authorized in a joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07, subdivision 2, or as otherwise allowed by this subdivision.

(b) This subdivision does not preempt or otherwise change the powers and duties of any city or county eligible for a local public health grant under section 145A.09.

(c) This subdivision does not preempt the authority to operate a community health services program of any city of the first or second class operating an existing program of community

health services located within a county with a population of 300,000 or more persons until the city council takes action to allow the county to preempt the city's powers and duties.

Subd. 3. **Medical consultant.** The community health board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 4. **Employees.** Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights. Failure to comply with this subdivision does not affect eligibility under section 145A.09.

Subd. 5a. **Duties.** (a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

(1) establish local public health priorities based on an assessment of community health needs and assets; and

(2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, within the limits of available funding.

In determining the mechanisms to address local public health priorities and achieve statewide outcomes, the community health board shall seek public input or consider the recommendations of the community health advisory committee and the following essential public health services:

(i) monitor health status to identify community health problems;

(ii) diagnose and investigate problems and health hazards in the community;

(iii) inform, educate, and empower people about health issues;

(iv) mobilize community partnerships to identify and solve health problems;

(v) develop policies and plans that support individual and community health efforts;

(vi) enforce laws and regulations that protect health and ensure safety;

(vii) link people to needed personal health care services;

(viii) ensure a competent public health and personal health care workforce;

(ix) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and

(x) research for new insights and innovative solutions to health problems.

(b) By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant under section 145A.131 shall notify the commissioner in writing of the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, that the board will address and the local priorities established under paragraph (a) that the board will address.

(c) Each community health board receiving a local public health grant under section 145A.131 must submit an annual report to the commissioner documenting progress toward the achievement of statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, and the local public health priorities established under paragraph (a), using reporting standards and procedures established by the commissioner and in compliance with all applicable federal requirements. If a community health board has identified additional local priorities for use of the local public health grant since the last notification of outcomes and priorities under paragraph (b), the community health board shall notify the commissioner of the additional local public health priorities in the annual report.

Subd. 7. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 9. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 10. **State and local advisory committees.** (a) A State Community Health Advisory Committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties. Notwithstanding section 15.059, the State Community Health Advisory Committee does not expire.

(b) The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 5a.

145A.12 POWERS AND DUTIES OF COMMISSIONER.

Subdivision 1. **Administrative and program support.** The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

(1) informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and

(2) administrative and program guidelines and standards, developed with the advice of the State Community Health Advisory Committee.

Subd. 2. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Subd. 7. **Statewide outcomes.** (a) The commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

(b) At least one statewide outcome must be established in each of the following public health areas:

(1) preventing diseases;

(2) protecting against environmental hazards;

(3) preventing injuries;

(4) promoting healthy behavior;

(5) responding to disasters; and

(6) ensuring access to health services.

(c) The commissioner shall use Minnesota's public health goals established under section 62J.212 and the essential public health services under section 145A.10, subdivision 5a, as a basis for the development of statewide outcomes.

(d) The statewide maternal and child health outcomes established under section 145.8821 shall be included as statewide outcomes under this section.

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), shall develop statewide outcomes for the local public health grant established under section 145A.131, based on state and local assessment data regarding the health of Minnesota residents, the essential public health services under section 145A.10, and current Minnesota public health goals established under section 62J.212.

148.01 CHIROPRACTIC.

Subd. 3. **Inclusions.** Chiropractic practice includes those noninvasive means of clinical, physical, and laboratory measures and analytical x-ray of the bones of the skeleton which are necessary to make a determination of the presence or absence of a chiropractic condition. The practice of chiropractic may include procedures which are used to prepare the patient for chiropractic adjustment or to complement the chiropractic adjustment. The procedures may not be used as independent therapies or separately from chiropractic adjustment. No device which utilizes heat or sound shall be used in the treatment of a chiropractic condition unless it has been approved by the Federal Communications Commission. No device shall be used above the neck of the patient. Any chiropractor who utilizes procedures in violation of this subdivision shall be guilty of unprofessional conduct and subject to disciplinary procedures according to section 148.10.

148.6440 PHYSICAL AGENT MODALITIES.

Subdivision 1. **General considerations.** (a) Occupational therapy practitioners who intend to use superficial physical agent modalities must comply with the requirements in subdivision 3. Occupational therapy practitioners who intend to use electrotherapy must comply with the requirements in subdivision 4. Occupational therapy practitioners who intend to use ultrasound devices must comply with the requirements in subdivision 5. Occupational therapy practitioners who are licensed as occupational therapy assistants and who intend to use physical agent modalities must also comply with subdivision 6.

(b) Use of superficial physical agent modalities, electrical stimulation devices, and ultrasound devices must be on the order of a licensed health care professional acting within the licensed health care professional's scope of practice.

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

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

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

(b) If an occupational therapy practitioner has successfully completed a specific course previously reviewed and approved by the commissioner as provided for in subdivision 7, and has submitted the written documentation required in paragraph (a) within 30 calendar days from the course date, the occupational therapy practitioner awaiting written approval from the commissioner may use physical agent modalities under the supervision of a licensed occupational therapist practitioner listed on the roster of persons approved to use physical agent modalities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Requirements for use of electrotherapy.** (a) An occupational therapy practitioner may use electrotherapy if the occupational therapy practitioner has received theoretical training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Requirements for use of ultrasound.** (a) An occupational therapy practitioner may use an ultrasound device if the occupational therapy practitioner has received theoretical training and clinical application training in the use of ultrasound and been granted approval as provided in subdivision 7.

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

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

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

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

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

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

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

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

(2) evaluate biophysical effects of ultrasound;

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

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

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

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

Subd. 6. **Occupational therapy assistant use of physical agent modalities.** An occupational therapy practitioner licensed as an occupational therapy assistant may set up and implement treatment using physical agent modalities if the licensed occupational therapy

assistant meets the requirements of this section, has applied for and received written approval from the commissioner to use physical agent modalities as provided in subdivision 7, has demonstrated service competency for the particular modality used, and works under the direct supervision of an occupational therapy practitioner licensed as an occupational therapist who has been granted approval as provided in subdivision 7. An occupational therapy practitioner licensed as an occupational therapy assistant who uses superficial physical agent modalities must meet the requirements of subdivision 3. An occupational therapy practitioner licensed as an occupational therapy assistant who uses electrotherapy must meet the requirements of subdivision 4. An occupational therapy practitioner licensed as an occupational therapy assistant who uses ultrasound must meet the requirements of subdivision 5. An occupational therapy practitioner licensed as an occupational therapist may not delegate evaluation, reevaluation, treatment planning, and treatment goals for physical agent modalities to an occupational therapy practitioner licensed as an occupational therapy assistant.

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

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

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

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

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

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

148.7808 REGISTRATION; REQUIREMENTS.

Subd. 2. **Registration by equivalency.** The board may register by equivalency an applicant who:

(1) submits the application materials and fees required under subdivision 1, clauses (1) to (8) and (10) to (12); and

(2) provides evidence satisfactory to the board of current certification by the National Athletic Trainers Association Board of Certification.

Applicants who were certified by the National Athletic Trainers Association through the "grandfather" process prior to 1971 are exempt from completing subdivision 1, clauses (2) and (9).

148.7813 DISCIPLINARY PROCESS.

Subdivision 1. **Investigation of complaints.** Upon receipt of a complaint or other communication pursuant to section 214.13, subdivision 6, that alleges or implies a violation of sections 148.7801 to 148.7815 by an applicant or registered athletic trainer, the board shall follow the procedures in section 214.10.

Subd. 2. **Grounds for disciplinary action.** The board may impose disciplinary action as described in subdivision 3 against an athletic trainer whom the board, after a hearing under the contested case provisions of chapter 14, determines:

(1) has knowingly made a false statement on a form required by the board for registration or registration renewal;

(2) has provided athletic training services in a manner that falls below the standard of care of the profession;

(3) has violated sections 148.7801 to 148.7815 or the rules adopted under these sections;

(4) is or has been afflicted with any physical, mental, emotional, or other disability, or addiction that, in the opinion of the board, adversely affects the person's ability to practice athletic training;

(5) has failed to cooperate with an investigation by the board;

(6) has been convicted or has pled guilty or nolo contendere to an offense that in the opinion of the board reasonably relates to the practice of athletic training or that bears on the athletic trainer's ability to practice athletic training;

(7) has aided and abetted in any manner a person in violating sections 148.7801 to 148.7815;

(8) has been disciplined by an agency or board of another state while in the practice of athletic training;

(9) has shown dishonest, unethical, or unprofessional conduct while in the practice of athletic training that is likely to deceive, defraud, or harm the public;

(10) has violated a state or federal law, rule, or regulation that in the opinion of the board reasonably relates to the practice of athletic training;

(11) has behaved in a sexual manner or what may reasonably be interpreted by a patient as sexual, or was verbally seductive or sexually demeaning to a patient;

(12) has misused alcohol, drugs, or controlled substances; or

(13) has violated an order issued by the board.

Subd. 3. **Disciplinary actions.** When grounds for disciplinary action exist under subdivision 2, the board may take one or more of the following actions:

(1) deny the right to practice;

(2) revoke the right to practice;

(3) suspend the right to practice;

(4) impose limitations on the practice of the athletic trainer;

(5) impose conditions on the practice of the athletic trainer;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the athletic trainer of any economic advantage gained by reason of the violation charged, or to discourage repeated violations;

(7) censure or reprimand the athletic trainer; or

(8) take any other action justified by the facts of the case.

Subd. 4. **Reinstatement.** An athletic trainer who has had registration revoked cannot apply for reinstatement. A suspended athletic trainer shall be reinstated upon evidence satisfactory to the board of fulfillment of the terms of suspension. All requirements of section 148.7809 to renew registration, if applicable, must also be met before reinstatement.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 32. **Review and evaluation of ongoing studies.** The commissioner shall review all ongoing studies, reports, and program evaluations completed by the Department of Human Services for state fiscal years 2006 through 2010. For each item, the commissioner shall report the legislature's appropriation for that work, if any, and the actual reported cost of the completed work by the Department of Human Services. The commissioner shall make recommendations to the legislature about which studies, reports, and program evaluations required by law on an ongoing basis are duplicative, unnecessary, or obsolete. The commissioner shall repeat this review every five fiscal years.

325H.06 NOTICE TO CONSUMER.

The tanning facility owner or operator shall provide each consumer under the age of 18, before initial exposure at the facility, with a copy of the following warning, which must be signed, witnessed, and dated as indicated in the warning:

"WARNING STATEMENT

This statement must be read and signed by the consumer BEFORE first exposure to ultraviolet radiation for tanning purposes at the below signed facility.

DANGER - ULTRAVIOLET RADIATION WARNING

-Follow instructions.

-Avoid overexposure. As with natural sunlight, overexposure can cause eye and skin injury and allergic reactions. Repeated exposure may cause premature aging of the skin and skin cancer.

-Wear protective eyewear.

FAILURE TO USE PROTECTIVE EYEWEAR MAY RESULT IN SEVERE BURNS OR LONG-TERM INJURY TO THE EYES.

-Medications or cosmetics may increase your sensitivity to the ultraviolet radiation. Consult a physician before using sunlamp or tanning equipment if you are using medications or have a history of skin problems or believe yourself to be especially sensitive to sunlight.

I have read the above warning and understand what it means before undertaking any tanning equipment exposure.

.....

Signature of Operator of Tanning Facility or Equipment

.....

Signature of Consumer

.....

Print Name of Consumer

.....

Date

OR

The consumer is illiterate and/or visually impaired and I have read the warning statement aloud and in full to the consumer in the presence of the below signed witness.

.....

Signature of Operator of Tanning Facility or Equipment

.....

Witness

.....

Date"

325H.08 CONSENT REQUIRED.

Before allowing the initial exposure at a tanning facility of a person under the age of 16, the owner or operator shall witness the person's parent's or legal guardian's signing and dating of the warning statement required under section 325H.06.

Laws 2011, First Special Session chapter 9, article 6, section 95 Subdivisions 1, 2, 3, 4,

Sec. 95. MINNESOTA AUTISM SPECTRUM DISORDER TASK FORCE.

Subdivision 1. **Members.** (a) The Autism Spectrum Disorder Task Force is composed of 19 members, appointed as follows:

(1) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(2) two members of the house of representatives, one from the majority party, appointed by the speaker of the house, and one from the minority party, appointed by the minority leader;

(3) two members who are family members of individuals with autism spectrum disorder (ASD), one of whom shall be appointed by the majority leader of the senate, and one of whom shall be appointed by the speaker of the house;

(4) one member appointed by the Minnesota chapter of the American Academy of Pediatrics who is a developmental behavioral pediatrician;

(5) one member appointed by the Minnesota Academy of Family Physicians who is a family practice physician;

(6) one member appointed by the Minnesota Psychological Association who is a neuropsychologist;

(7) one member appointed by the majority leader of the senate who represents a minority autism community;

(8) one member representing the directors of public school student support services;

(9) one member appointed by the Minnesota Council of Health Plans;

(10) three members who represent autism advocacy groups, two of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the majority leader of the senate; and

(11) one member appointed by each of the respective commissioners of the following departments: education, employment and economic development, health, and human services.

(b) Appointments must be made by September 1, 2011. The senate member appointed by the majority leader of the senate shall convene the first meeting of the task force no later than October 1, 2011. The task force shall elect a chair from among members at the first meeting. The task force shall meet at least six times per year.

Subd. 2. **Duties.** (a) The task force shall develop an autism spectrum disorder statewide strategic plan that focuses on improving awareness, early diagnosis, and intervention and on ensuring delivery of treatment and services for individuals diagnosed with an autism spectrum disorder, including the coordination and accessibility of cost-effective treatments and services throughout the individual's lifetime.

(b) The task force shall coordinate with existing efforts relating to autism spectrum disorders at the Departments of Education, Employment and Economic Development, Health, and Human Services and at the University of Minnesota and other agencies and organizations as the task force deems appropriate.

Subd. 3. **Report.** The task force shall submit its strategic plan to the legislature by January 15, 2013. The task force shall continue to provide assistance with the implementation of the strategic plan, as approved by the legislature, and shall submit a progress report by January 15, 2014, and by January 15, 2015, on the status of implementation of the strategic plan, including any draft legislation necessary for implementation.

Subd. 4. **Expiration.** The task force expires June 30, 2015, unless extended by law.

2500.0100 DEFINITIONS.

Subp. 3. **Acupuncture.** "Acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment.

2500.0100 DEFINITIONS.

Subp. 4b. **Diagnosis.** "Diagnosis" means the physical, clinical, and laboratory examination of the patient, and the use of X-ray for diagnostic purposes within the scope of practice described in Minnesota Statutes, sections 148.01 to 148.10.

2500.0100 DEFINITIONS.

Subp. 9b. **Practice of chiropractic.** "Practice of chiropractic" includes the examination, diagnosis, prognosis, and treatment by chiropractic methods, or the rendering of opinions pertaining to those methods, for the purposes of determining a course of action in the best interests of the patient, such as a treatment plan or appropriate referral, or both. The methods may include those procedures preparatory or complementary to a chiropractic adjustment or other normal chiropractic regimen and rehabilitation of the patient as taught in accredited chiropractic schools or programs, pursuant to Minnesota Statutes, section 148.06.

2500.4000 REHABILITATIVE TREATMENT.

Rehabilitative therapy, within the context of the practice of chiropractic, may be done to prepare a patient for chiropractic adjustment or to complement the chiropractic adjustment, provided the treating chiropractor initiates the development and authorization of the rehabilitative therapy.

The administration of the rehabilitative therapy is the responsibility of the treating chiropractor.

The rehabilitative therapy must be rendered under the direct supervision of qualified staff.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1450 INTRODUCTION.

Subp. 3. **Geographic area.** PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca and other geographical areas designated by the commissioner. If the geographic area is expanded beyond Dakota, Hennepin, and Itasca Counties, participating counties in the expanded area shall receive at least 180 days notice from the commissioner before implementation of PMAP and shall be governed by parts 9500.1450 to 9500.1464.

9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

Subp. 3. **Exclusions during phase-in period.** The 65 percent of medical assistance eligible persons in Hennepin County who were not randomly selected to participate in the former medical assistance prepaid demonstration project because they served as a control group must participate in PMAP. Hennepin County may temporarily exclude individuals' participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Counties participating in the prepaid medical assistance program for the first time after June 30, 1991, may temporarily exclude PMAP consumers from participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

9500.1456 IDENTIFICATION OF ENROLLEES.

A MHP shall identify enrollees in a way convenient to its normal operational procedures.

9505.5300 APPLICABILITY.

Parts 9505.5300 to 9505.5325 govern the Minnesota Family Planning Program Section 1115 Demonstration Project. The demonstration project is a Medicaid waiver demonstration project approved by the Centers for Medicare and Medicaid Services to provide federally approved contraception management services to eligible low-income persons.

9505.5305 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5300 to 9505.5325 have the meanings given them in this part.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written demonstration project application to the department for a determination of eligibility for the demonstration project.

Subp. 3. **Certified family planning services provider.** "Certified family planning services provider" means a family planning services provider that meets the requirements of part 9505.5315, subpart 1.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subp. 5. **Contraception management services.** "Contraception management services" means a scope of family planning services limited to initiating or obtaining an enrollee's contraceptive method and maintaining effective use of that method.

Subp. 6. **Countable income.** "Countable income" means the income, including deemed income, used to determine a person's eligibility for the demonstration project.

Subp. 7. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256B.02, subdivision 6.

Subp. 8. **Demonstration project.** "Demonstration project" means the Minnesota Family Planning Program Section 1115 Demonstration Project, Project Number 11-W-00183/5.

Subp. 9. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 10. **Enrollee.** "Enrollee" means a person enrolled in the demonstration project.

Subp. 11. **Family planning services provider.** "Family planning services provider" includes the providers listed in part 9505.0280, subpart 3, and clinical nurse specialists, laboratories, ambulatory surgical centers, federally qualified health centers, Indian Health Services, public health nursing clinics, and physician assistants who are authorized providers under part 9505.0195.

Subp. 12. **Family size.** "Family size" means the number of people used to determine a person's income standard. The family size includes the person and the following people who live with the person: the person's spouse, the biological and adoptive children of the person who are under age 21, and the biological and adoptive children of the person's spouse who are under age 21.

Subp. 13. **Minnesota health care program.** "Minnesota health care program" means medical assistance under Minnesota Statutes, chapter 256B, general assistance medical care under Minnesota Statutes, section 256D.03, and MinnesotaCare under Minnesota Statutes, chapter 256L.

Subp. 14. **Presumptive eligibility.** "Presumptive eligibility" means the temporary period of eligibility for the demonstration project that is determined at the point of service by a certified family planning services provider.

Subp. 15. **Qualified noncitizen eligible for medical assistance with federal financial participation.** "Qualified noncitizen eligible for medical assistance with federal financial participation" means a person that meets the requirements of Minnesota Statutes, section 256B.06, subdivision 4.

Subp. 16. **Resident.** "Resident" means a person who meets the requirements in part 9505.0030.

9505.5310 DEMONSTRATION PROJECT ELIGIBILITY, APPLICATION, ENROLLMENT, AND DOCUMENTATION.

Subpart 1. **General eligibility.** The eligibility and coverage requirements in this subpart apply to applicants and enrollees.

A. Except as provided in subpart 2, an applicant or enrollee must meet the following requirements to be eligible for the demonstration project:

(1) be a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation;

(2) be a Minnesota resident;

(3) be 15 years of age or older and under age 50;

(4) have countable income at or below 200 percent of the federal poverty guidelines for the family size. Countable income is determined according to the income rules applied in eligibility determinations for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, and United States Code, title 42, chapter 7, subchapter XIX, section 1396u-1, as follows:

(a) income includes all categories of earned and unearned income used in eligibility determinations for families and children under the medical assistance program;

(b) income does not include any categories of income that are excluded for purposes of determining eligibility for families and children in the medical assistance program;

(c) income methodologies, such as earned income deductions and disregards, used to determine eligibility for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, subdivisions 1a and 1c, do not apply to the determination of countable income; and

(d) income deeming requirements used to determine eligibility for families and children in the medical assistance program apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person;

(5) not be pregnant;

(6) not be enrolled in the Minnesota health care program or other health service program administered by the department; and

(7) not be an institutionalized individual as described under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009.

B. Participation in the demonstration project does not require the consent of anyone other than the applicant.

C. Asset requirements do not apply to applicants and enrollees.

D. Applicants and enrollees must report available third-party coverage and cooperate with the department in obtaining third-party payments. The department shall waive this requirement if the applicant or enrollee states that reporting third-party coverage could violate the applicant's or enrollee's privacy.

Subp. 2. **Presumptive eligibility.** Services covered under the demonstration project may be provided during a presumptive eligibility period.

A. A certified family planning services provider will screen a person for demonstration project eligibility using preliminary information provided by the person. A person who, based on the preliminary information, appears to meet the eligibility requirements in part 9505.5310, subpart 1, item A, subitems (2) to (6), is presumptively eligible for the demonstration project.

B. The presumptive eligibility period begins the first day of the month that a certified family planning services provider determines that a person is presumptively eligible. The presumptive eligibility period ends the last day of the month following the month that the certified family planning services provider determines that a person was presumptively eligible.

C. A person determined presumptively eligible must comply with part 9505.5310, subpart 1, item D.

D. A person may receive presumptive eligibility once during a 12-month period.

Subp. 3. **Enrollment.** An applicant must apply for the demonstration project using forms provided by the department.

A. The department or county agency must determine an applicant's eligibility for the demonstration project within 45 days of receipt of a completed application.

B. Except as provided in item C, eligibility begins the first day of the month of application. If a completed application form is submitted within 30 days of the request, the month of application includes the month the department or county agency receives a written request for the demonstration project consisting of at least the name of the applicant, a means to locate the applicant, and the signature of the applicant.

C. A person who is eligible under subparts 1 and 2 and files a demonstration project application during the presumptive eligibility period is eligible for ongoing coverage on the first day of the month following the month that presumptive eligibility ends.

Subp. 4. **Application and documentation.** The application and documentation requirements in this subpart apply to all applicants and enrollees.

A. An enrollee is eligible for the demonstration project for one year regardless of changes in income or family size. Eligibility will end prior to the annual renewal if the enrollee:

(1) dies;

(2) is no longer a Minnesota resident;

(3) voluntarily terminates eligibility;

(4) enrolls in the Minnesota health care program or other health service program administered by the department;

(5) reaches 50 years of age;

(6) becomes pregnant;

(7) becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009; or

(8) is no longer a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation.

B. Applicants and enrollees must document their income at application.

C. Enrollees must complete an annual application on forms provided by the department.

D. Applicants and enrollees must provide documentation of immigration status at application. The department or county agency will verify applicant and enrollee immigration status according to Minnesota Statutes, section 256.01, subdivision 18.

E. Applicants and enrollees must report a change in an eligibility factor to the department or county agency within ten days of learning about the change. Applicants and enrollees who fail to report a change that would have resulted in ineligibility for the demonstration project will be disenrolled from the demonstration project and will be ineligible for the demonstration project for a period of 12 months following the date of disenrollment. If the only unreported change is a pregnancy, applicants and enrollees will not be subject to the 12 months ineligibility period, but pregnant applicants and enrollees will be disenrolled from the demonstration project and may reapply for the demonstration project following the end of the pregnancy.

F. Applicants and enrollees must provide information, documents, and any releases requested by the department or county agency that are necessary to verify eligibility information. An applicant or enrollee who refuses to authorize verification of an eligibility factor, including a Social Security number, is not eligible for the demonstration project, except as provided in Code of Federal Regulations, title 42, section 435.910(h)(2).

G. Applicants must document citizenship as required by the federal Deficit Reduction Act of 2005, Public Law 109-71. Persons screened for presumptive eligibility under subpart 2 are not required to document citizenship.

H. An applicant may withdraw an application according to the provisions of part 9505.0090, subpart 4.

Subp. 5. **Enrollment.** To be considered for Minnesota health care program eligibility, an enrollee must complete the department's health care application. Applicants and enrollees shall not use a demonstration project application form to apply for the Minnesota health care program. People who complete the department's health care application and are determined ineligible for the Minnesota health care program, either at application or during enrollment, may authorize a demonstration project eligibility determination using the information provided in the department's health care application and updated at required intervals.

Subp. 6. **Confidentiality.** Private data about persons screened for eligibility, applicants, and enrollees must be disclosed according to the provisions of the following statutes and rules:

A. part 1205.0500 and Minnesota Statutes, chapter 13;

B. Minnesota Statutes, sections 144.291 to 144.298;

C. Minnesota Statutes, section 144.343;

D. Code of Federal Regulations, title 45, parts 160, 162, and 164; and

E. other applicable state and federal laws, statutes, rules, and regulations affecting the collection, storage, use, and dissemination of protected, private, and confidential health and other information.

Subp. 7. **Notices.** Applicants and enrollees may arrange to receive notices in a manner other than having notices mailed to the applicant's or enrollee's home address.

9505.5315 PROVIDERS OF FAMILY PLANNING SERVICES.

Subpart 1. **Certified family planning services provider requirements.** To become a certified family planning services provider, a family planning services provider must:

A. sign the business associate agreement;

B. complete required training;

C. provide information about presumptive eligibility to interested persons;

D. help interested persons complete demonstration project applications and forms;

E. use the department's eligibility verification system to verify a person screened for demonstration project eligibility does not receive Minnesota health care program coverage;

F. determine presumptive eligibility;

G. give required notices to a person screened for eligibility;

H. promptly forward completed applications and forms to the department; and

I. cooperate with department application tracking and program evaluation activities.

Subp. 2. **Covered services.** The demonstration project covers contraception management services and certain additional medical diagnosis or treatment services that are provided within the context of a visit for contraception management services. All services covered by the demonstration project are listed in Attachment B of the Centers for Medicare and Medicaid Services Special Terms and Conditions for the Minnesota Family Planning Program Section 1115 Demonstration, Project Number 11-W-00183/5 and its amendments, which are incorporated by reference. This document can be found at the Minnesota Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. Attachment B is subject to frequent change.

Subp. 3. **Payment for services.** Family planning services providers are paid for covered services as follows:

A. No cost-sharing requirements apply to services provided under the demonstration project.

B. Payments will be made on a fee-for-service basis to providers for services provided under the demonstration project.

C. All covered services provided during the presumptive eligibility period according to part 9505.5310, subpart 2, will be reimbursed.

D. The demonstration project is the payer of last resort. The demonstration project will not cover drugs that are covered under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A).

E. Parts 9505.2160 to 9505.2245, regarding surveillance and integrity review, apply to services provided under parts 9505.5300 to 9505.5325.

9505.5325 APPEALS.

Subpart 1. **Notice.** The commissioner must follow the notification procedures in part 9505.0125 if the commissioner denies, suspends, reduces, or terminates eligibility or covered health services, except as provided in subpart 3.

Subp. 2. **Appeal process.** A person aggrieved by a determination or action of the commissioner under parts 9505.5300 to 9505.5325 may appeal the department's or county agency's determination or action according to Minnesota Statutes, section 256.045, except as provided in subpart 3.

Subp. 3. **Denial of presumptive eligibility.** There is no right of appeal for a denial of presumptive eligibility.

9525.1580 CONTROL AND LOCATION OF SERVICES.

Subpart 1. **Definitions.** The terms used in subparts 2 and 3 have the meanings given them in this subpart.

A. "Related legal entities" means entities that share any governing board members or an executive director or are owned or partially owned by the same individual or individuals, or by related individuals.

B. "Related individuals" means individuals whose relationship to each other by blood, marriage, or adoption is not more remote than first cousin.

Subp. 2. **Control of services.** Training and habilitation services licensed under Minnesota Statutes, chapter 245B and licensed residential services must not be provided to the same person by related legal entities. This requirement does not apply:

A. to residential and day habilitation services directly administered by a county board or by the commissioner at a regional center;

B. to residential and day habilitation services offered by a training and habilitation services provider licensed before April 15, 1983; or

C. to services provided to a person who resides at home with the person's family or foster family and who is receiving a combination of day habilitation and residential based habilitation services under parts 9525.1800 to 9525.1930.

Subp. 3. **Location of services.** Training and habilitation services must be provided away from the residence of the person receiving services in communities where the person lives and works.