CHAPTER 144

DEPARTMENT OF HEALTH

144.05 GENERAL DUTIES OF COMMISSIONER; REPORTS.

Subdivision 1. **General duties.** The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens. This authority shall include but not be limited to the following:

(a) Conduct studies and investigations, collect and analyze health and vital data, and identify and describe health problems;

(b) Plan, facilitate, coordinate, provide, and support the organization of services for the prevention and control of illness and disease and the limitation of disabilities resulting therefrom;

(c) Establish and enforce health standards for the protection and the promotion of the public's health such as quality of health services, reporting of disease, regulation of health facilities, environmental health hazards and personnel;

(d) Affect the quality of public health and general health care services by providing consultation and technical training for health professionals and paraprofessionals;

(e) Promote personal health by conducting general health education programs and disseminating health information;

(f) Coordinate and integrate local, state and federal programs and services affecting the public's health;

(g) Continually assess and evaluate the effectiveness and efficiency of health service systems and public health programming efforts in the state; and

(h) Advise the governor and legislature on matters relating to the public's health.

Subd. 2. **Mission; efficiency.** It is part of the department's mission that within the department's resources the commissioner shall endeavor to:

(1) prevent the waste or unnecessary spending of public money;

(2) use innovative fiscal and human resource practices to manage the state's resources and operate the department as efficiently as possible;

(3) coordinate the department's activities wherever appropriate with the activities of other governmental agencies;

(4) use technology where appropriate to increase agency productivity, improve customer service, increase public access to information about government, and increase public participation in the business of government;

(5) utilize constructive and cooperative labor–management practices to the extent otherwise required by chapters 43A and 179A;

(6) include specific objectives in the performance report required under section 15.91 to increase the efficiency of agency operations, when appropriate; and

(7) recommend to the legislature, in the performance report of the department required under section 15.91, appropriate changes in law necessary to carry out the mission of the department.

History: *1995 c 248 art 11 s 11*

144.057 BACKGROUND STUDIES ON LICENSEES.

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.031. If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. **Responsibilities of the department of human services.** The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action.

Subd. 4. **Responsibilities of facilities.** Facilities described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities. The provision of section 245A.04, subdivision 3, paragraph (d), shall apply to applicants, licensees, or an individual's refusal to cooperate with the completion of the background studies.

History: *1995 c 229 art 3 s 4*

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Access to data.** With the exception of summary data, data on individuals that is collected, maintained, used, or disseminated by the commissioner of health under subdivision 1 is private data on individuals and shall not be disclosed to others except:

(1) under section 13.05;

(2) under a valid court order;

(3) to the nursing home or boarding care home in which the individual resided at the time the assessment was completed;

(4) to the commissioner of human services; or

(5) to county home care staff for the purpose of assisting the individual to be discharged from a nursing home or boarding care home and returned to the community.

Subd. 3. **Level of care criteria; modifications.** The commissioner shall seek appropriate federal waivers to implement this subdivision. Notwithstanding any laws or rules to the contrary, effective July 1, 1996, Minnesota's level of care criteria for admission of any person to a nursing facility licensed under chapter 144A, or a boarding care home licensed under sections 144.50 to 144.56, are modified as follows:

(1) the resident reimbursement classifications and terminology established by rule under sections 256B.41 to 256B.48 are the basis for applying the level of care criteria changes;

(2) an applicant to a certified nursing facility or certified boarding care home who is dependent in one or two case mix activities of daily living, is classified as a case mix A, and is independent in orientation and self–preservation, is reclassified as a high function class A person and is not eligible for admission to Minnesota certified nursing facilities or certified boarding care homes;

(3) applicants in clause (2) who are eligible for assistance as determined under sections 256B.055 and 256B.056 or meet eligibility criteria for section 256B.0913 are eligible for a service allowance under section 256B.0913, subdivision 15, and are not eligible for services under sections 256B.0913, subdivisions 1 to 14, and 256B.0915. Applicants in clause (2) shall have the option of receiving personal care assistant and home health aide services under section 256B.0625, if otherwise eligible, or of receiving the service allowance option, but not both. Applicants in clause (2) shall have the option of residing in community settings under sections 256I.01 to 256I.06, if otherwise eligible, or receiving the services allowance option under section 256B.0913, subdivision 15, but not both;

(4) residents of a certified nursing facility or certified boarding care home who were admitted before July 1, 1996, or individuals receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915, before July 1, 1996, are not subject to the new level of care criteria unless the resident is discharged home or to another service setting other than a certified nursing facility or certified boarding care home and applies for admission to a certified nursing facility or certified boarding care home after June 30, 1996;

(5) the local screening teams under section 256B.0911 shall make preliminary determinations concerning the existence of extraordinary circumstances and may authorize an admission for a short–term stay at a certified nursing facility or certified boarding care home in accordance with a treatment and discharge plan for up to 30 days per year; and

(6) an individual deemed ineligible for admission to Minnesota certified nursing facilities is entitled to an appeal under section 256.045.

If the commissioner determines upon appeal that an applicant in clause (2) presents extraordinary circumstances including but not limited to the absence or inaccessibility of suitable alternatives, contravening family circumstances, and protective service issues, the applicant may be eligible for admission to Minnesota certified nursing facilities or certified boarding care homes.

Subd. 3a. **Exception.** Subdivision 3 does not apply to a facility whose rates are subject to section 256I.05, subdivision 2.

History: *1995 c 207 art 6 s 1,2; 1995 c 259 art 1 s 31*

144.0723 CLIENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.

Subdivision 1. **Client classifications.** The commissioner of health shall establish classifications based upon the assessment of each client in intermediate care facilities for the mentally retarded conducted after December 31, 1992, under section 256B.501, subdivision 3g. The classifications established by the commissioner must conform to section 256B.501, subdivision 3g, and subsequent rules established by the commissioner of human services to set payment rates for intermediate care facilities for the mentally retarded.

Subd. 2. **Notice of client classification.** The commissioner of health shall notify each intermediate care facility for the mentally retarded of the classifications established under subdivision 1 for each client residing in the facility. The notice must inform the intermediate care facility for the mentally retarded of the classifications that are assigned and the opportunity to request a reconsideration of any classifications assigned. The notice of classification must be sent by first–class mail.

Subd. 3. **Request for reconsideration.** The intermediate care facility for the mentally retarded may request that the commissioner reconsider the assigned classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days after the receipt of the notice of client classification. The request for reconsideration must include the name of the client, the name and address of the facility in which the client resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the client and services provided to the client at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 4. **Access to information.** Annually, at the interdisciplinary team meeting, the intermediate care facility for the mentally retarded shall inform the client or the client's representative and case manager of the client's most recent classification as determined by the department of health. Upon written request, the intermediate care facility for the mentally retarded must give the client's case manager, the client, or the client's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings.

Subd. 5. [Repealed, 1995 c 207 art 7 s 43]

Subd. 6. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. Within 15 working days after receiving the request for reconsideration, the commissioner shall affirm or modify the original client classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The intermediate care facility for the mentally retarded shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

[For text of subds 7 and 8, see M.S.1994]

History: *1995 c 207 art 7 s 1–5*

144.077 MOBILE HEALTH CARE PROVIDERS.

Subdivision 1. **Definition.** "Mobile health evaluation and screening provider" means any provider who is transported in a vehicle mounted unit, either motorized or trailered, and readily movable without disassembling, and who regularly provides evaluation and screening services in more than one geographic location. "Mobile health evaluation and screening provider" does not include any ambulance medical transportation type services or any mobile health service provider affiliated, owned and operated, or under contract with a licensed health care facility or provider, managed care entity licensed under chapter 62D or 62N or Minnesota licensed physician or dentist, nor does it include fixed location providers who transfer or move during the calendar year. All mobile health evaluation and screening providers must be directly supervised by a physician licensed under chapter 147.

Subd. 2. **Licensure requirements.** A mobile health evaluation and screening provider shall be required to comply with all licensing reporting and certification, sanitation, and other requirements and regulations that apply to a health care provider supplying similar services as a fixed location provider. A mobile health evaluation and screening provider shall be subject to regulation and order of the department of health.

Subd. 3. **Registration requirements.** A mobile health evaluation and screening provider shall register with the commissioner and file the anticipated locations of practice, schedules, and routes annually no later than January 15. The mobile health evaluation and screening provider shall also include the name and address of the supervising physician. A mobile health evaluation and screening provider shall provide at least 30 days' written notice to the populations they intend to serve.

History: *1995 c 135 s 1*

144.121 X-RAY MACHINES AND FACILITIES USING RADIUM.

[For text of subds 1 to 4, see M.S.1994]

Subd. 5. **Examination for individual operating X-ray equipment.** After January 1, 1997, an individual in a facility with X-ray equipment for use on humans that is registered under subdivision 1 may not operate, nor may the facility allow the individual to operate, X-ray equipment unless the individual has passed an examination approved by the commissioner of health, or an examination determined to the satisfaction of the commissioner of health to be an equivalent national, state, or regional examination, that demonstrates the individual's knowledge of basic radiation safety, proper use of X-ray equipment, darkroom and film processing, and quality assurance procedures. The commissioner shall establish by rule criteria for the approval of examinations required for an individual operating an X-ray machine in Minnesota.

Subd. 6. **Inspection.** At the time a facility with X-ray equipment is inspected by the commissioner of health in accordance with subdivision 2, an individual operating X-ray equipment in the facility must be able to show compliance with the requirements of subdivision 5.

Subd. 7. **Advisory committee.** The commissioner of health shall establish an advisory committee for advice on the examination required under subdivision 5. The committee shall consist of 15 members including, but not limited to, a representative of each of the following associations and licensing boards: medical, dental, chiropractic, podiatric, nursing, and hospital, and a representative of registered radiologic technologists and laboratory technicians. The committee shall expire March 31, 1996.

History: *1995 c 146 s 1-3*

144.122 LICENSE AND PERMIT FEES.

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the

expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the department of finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner, for fiscal years 1996 and beyond, shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals)	$1,017
Non–JCAHO hospitals	$762 plus $34 per bed
Nursing home	$78 plus $19 per bed

For fiscal years 1996 and beyond, the commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$517
Boarding care homes	$78 plus $19 per bed
Supervised living facilities	$78 plus $19 per bed.

History: *1995 c 207 art 9 s 4*

144.1222 PUBLIC POOLS; ENCLOSED SPORTS ARENAS.

Subdivision 1. **Public pools.** The commissioner of health shall be responsible for the adoption of rules and enforcement of applicable laws and rules relating to the operation, maintenance, design, installation, and construction of public pools and facilities related to them. The commissioner shall adopt rules governing the collection of fees under section 144.122 to cover the cost of pool construction plan review, monitoring, and inspections.

Subd. 2. **Pools used for treatment or therapy.** A pool used by a medical or rehabilitation facility to facilitate treatment or therapy, to which only authorized access is allowed and which is not open for any other public use, is exempt from the requirements of Minnesota Rules, part 4717.1050, regarding warning signs, and Minnesota Rules, part 4717.1650, subpart 1, regarding placards.

Subd. 3. **Enclosed sports arenas.** The commissioner of health shall be responsible for the adoption of rules and enforcement of applicable laws and rules relating to indoor air quality in the operation and maintenance of enclosed sports arenas.

History: *1995 c 165 s 1*

144.1464 SUMMER HEALTH CARE INTERNS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals and clinics that agree to:

(1) provide secondary and post–secondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and post–secondary summer health care interns;

(3) pay one–half the costs of employing the secondary and post–secondary summer health care intern, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour;

(4) interview and hire secondary and post–secondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each post–secondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital or clinic, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school;

(2) be from a school district in proximity to the facility; and

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(c) In order to be eligible to be hired as a post–secondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a two–year or four–year degree program and be planning on enrolling in or be enrolled in that degree program;

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility; and

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

(d) Hospitals and clinics awarded grants may employ pupils as secondary and post–secondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals and clinics meeting the requirements of subdivision 2. The grants must be used to pay one–half of the costs of employing secondary and post–secondary pupils in a hospital or clinic during the course of the program. No more than 50 percent of the participants may be post–secondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or post–secondary institution to participate in the program and no more than one–half of the number of pupils selected may be from the seven–county metropolitan area.

Subd. 4. **Contract.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and post–secondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

History: *1995 c 234 art 8 s 29–31*

144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM.

Subdivision 1. **Definition.** "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 5,000, according to United States Census Bureau statistics, outside the seven–county metropolitan area;

(2) has 100 or fewer beds;

(3) is not for profit; and

(4) has not been awarded a grant under the federal rural health transition grant program, which would be received concurrently with any portion of the grant period for this program.

[For text of subds 2 to 5, see M.S.1994]

History: *1995 c 234 art 8 s 32*

144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education services office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) administer the program of financial assistance established under section 144.1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;

(4) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(5) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

(6) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(7) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on–site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(8) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(9) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(10) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council; and

(11) carry out other activities necessary to address rural health problems.

History: *1995 c 212 art 3 s 59*

144.1484 RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.

Subdivision 1. **Sole community hospital financial assistance grants.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short–term services; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 40 or fewer licensed beds; and (4) demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded under this program will not be used to supplant local support

for the hospital. The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing hospital projects; and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals. The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's operating loss margin (total operating losses as a percentage of total operating revenue) for the two most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

[For text of subd 2, see M.S.1994]

History: *1995 c 234 art 8 s 33*

144.1486 RURAL COMMUNITY HEALTH CENTERS.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. **Eligibility requirements.** In order to qualify for community health center program funding, a project must:

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area. "Rural" means an area of the state outside the seven–county Twin Cities metropolitan area and outside of the Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas;

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax–exempt status within six months of accepting community health center grant funds;

(3) result in a locally owned and operated community health center that provides primary and preventive health care services, and incorporates quality assurance, regular reviews of clinical performance, and peer review;

(4) seek to employ midlevel professionals, where appropriate;

(5) demonstrate community and popular support and provide a 20 percent local match of state funding; and

(6) propose to serve an area that is not currently served or was not served prior to establishment of a state–funded community health center by a federally certified medical organization.

[For text of subds 5 to 10, see M.S.1994]

History: *1995 c 234 art 8 s 34*

144.1487 LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS.

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

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

[For text of subd 2, see M.S.1994]

History: *1995 c 212 art 3 s 44; 1995 c 234 art 8 s 35*

144.1488 PROGRAM ADMINISTRATION AND ELIGIBILITY.

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

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

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

(3) develop and disseminate application materials to sites;

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

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

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

(7) verify the eligibility of program participants;

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

(9) arrange for the payment of qualifying educational loans for program participants;

(10) monitor the obligated service of program participants;

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

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

(13) enforce penalties for default.

Subd. 2. [Repealed, 1995 c 212 art 3 s 60; 1995 c 234 art 8 s 57]

[For text of subd 3, see M.S.1994]

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

(b) In selecting physicians for participation, the commissioner shall give priority to physicians who are board certified or have completed a residency in family practice, osteopathic general practice, obstetrics and gynecology, internal medicine, or pediatrics. A physician selected for participation is not eligible for loan repayment until the physician has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner.

History: *1995 c 212 art 3 s 45,46; 1995 c 234 art 8 s 36,37*

144.1489 OBLIGATIONS OF PARTICIPANTS.

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

[For text of subd 2, see M.S.1994]

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

Subd. 4. **Affidavit of service required.** Within 30 days of the start of obligated service, and by February 1 of each succeeding calendar year, a participant shall submit an affidavit to the commissioner stating that the participant is providing the obligated service and which is signed by a representative of the organizational entity in which the service is provided. Participants must provide written notice to the commissioner within 30 days of: a change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice.

[For text of subds 5 and 6, see M.S.1994]

History: *1995 c 212 art 3 s 47–49; 1995 c 234 art 8 s 38–40*

144.1490 RESPONSIBILITIES OF THE LOAN REPAYMENT PROGRAM.

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

Subd. 2. **Procedure for loan repayment.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the commissioner is to make payments. The participant shall submit to the commissioner all payment books for the designated loan or loans or all monthly billings for the designated loan or loans within five days of receipt. The commissioner shall make payments in accordance with the terms and conditions of the designated loans, in an amount not to exceed $20,000 when annualized. If the amount paid by the commissioner is less than $20,000 during a 12–month period, the commissioner shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000. The total amount paid by the commissioner must not exceed the amount of principal and accrued interest of the designated loans.

History: *1995 c 212 art 3 s 50; 1995 c 234 art 8 s 41*

144.1491 FAILURE TO COMPLETE OBLIGATED SERVICE.

[For text of subd 1, see M.S.1994]

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

History: *1995 c 212 art 3 s 51; 1995 c 234 art 8 s 42*

144.1493 NURSING GRANT PROGRAM.

Subdivision 1. **Establishment.** A nursing grant program is established under the supervision of the commissioner of health and the administration of the metropolitan healthcare foundation's project LINC to provide grants to Minnesota health care facility employees seeking to complete a baccalaureate or master's degree in nursing.

Subd. 2. **Responsibility of metropolitan healthcare foundation's project LINC.** The metropolitan healthcare foundation's project LINC shall administer the grant program and award grants to eligible health care facility employees. To be eligible to receive a grant, a person must be:

(1) an employee of a health care facility located in Minnesota, whom the facility has recommended to the metropolitan healthcare foundation's project LINC for consideration;

(2) working part time, up to 32 hours per pay period, for the health care facility, while maintaining full salary and benefits;

(3) enrolled full time in a Minnesota school or college of nursing to complete a baccalaureate or master's degree in nursing; and

(4) a resident of the state of Minnesota.

The grant must be awarded for one academic year but is renewable for a maximum of six semesters or nine quarters of full–time study, or their equivalent. The grant must be used for tuition, fees, and books. Priority in awarding grants shall be given to persons with the greatest financial need. The health care facility may require its employee to commit to a reasonable postprogram completion of employment at the health care facility as a condition for the financial support the facility provides.

Subd. 3. **Responsibility of commissioner.** The commissioner shall distribute money each year to the metropolitan healthcare foundation's project LINC to be used to award grants under this section, provided that the commissioner shall not distribute the money un-

less the metropolitan healthcare foundation's project LINC matches the money with an equal amount from nonstate sources. The metropolitan healthcare foundation's project LINC shall expend nonstate money prior to expending state money and shall return to the commissioner all state money not used each year for nursing program grants to be redistributed under this section. The metropolitan healthcare foundation's project LINC shall report to the commissioner on its program activity as requested by the commissioner.

History: *1995 c 234 art 8 s 43*

144.218 NEW CERTIFICATES OF BIRTH.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. **Incomplete, incorrect, and modified certificates.** If a court finds that a birth certificate is incomplete, inaccurate or false, or if it is being issued pursuant to section 259.10, subdivision 2, it may order the registration of a new certificate, and, if necessary, set forth the correct information in the order. Upon receipt of the order the state registrar shall register a new certificate containing the findings of the court, and the prior certificate shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

History: *1995 c 259 art 1 s 32*

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

[For text of subds 1 and 2, see M.S.1994]

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12. The commissioner may disclose to a local board of health, as defined in section 145A.02, subdivision 2, health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or developmental delay in order to assure access to appropriate health, social, or educational services.

[For text of subds 3 to 5, see M.S.1994]

History: *1995 c 259 art 1 s 33*

144.226 FEES.

Subdivision 1. **Which services are for fee.** The fees for any of the following services shall be in an amount prescribed by rule of the commissioner:

(a) The issuance of a certified copy or certification of a vital record, or a certification that the record cannot be found;

(b) The replacement of a birth certificate;

(c) The filing of a delayed registration of birth or death;

(d) The alteration, correction, or completion of any vital record, provided that no fee shall be charged for an alteration, correction, or completion requested within one year after the filing of the certificate; and

(e) The verification of information from or noncertified copies of vital records. Fees charged shall approximate the costs incurred in searching and copying the records. The fee shall be payable at time of application.

[For text of subds 2 and 3, see M.S.1994]

History: *1995 c 207 art 9 s 5*

144.335 ACCESS TO HEALTH RECORDS.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient designates in writing as a representative. Except for minors who have received health care services pursuant to sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is licensed to furnish the services pursuant to chapter 147, 148, 148B, 150A, 151, or 153; (2) a home care provider licensed under section 144A.46; (3) a health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

(c) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

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

(b) Except as provided in paragraph (e), upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

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

(d) A provider as defined in subdivision 1, clause (b)(3), shall release information upon written request unless, prior to the request, a provider as defined in subdivision 1, clause (b)(1), has designated and described a specific basis for withholding the information as authorized by paragraph (c).

(e) A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section 13.03, subdivision 6, or as provided in section 611A.90. This paragraph does not limit the right of a patient to view the videotape.

[For text of subd 3, see M.S.1994]

Subd. 3a. **Patient consent to release of records; liability.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law. Except as provided in paragraph (c), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

(b) This subdivision does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency; or

(2) to other providers within related health care entities when necessary for the current treatment of the patient.

(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third–party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

(d) Until June 1, 1996, paragraph (a) does not prohibit the release of health records to qualified personnel solely for purposes of medical or scientific research, if the patient has not objected to a release for research purposes and the provider who releases the records makes a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

(f) Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Paragraph (a) applies to consents given under this paragraph.

Subd. 3b. **Release of records to commissioner of health or health data institute.** Subdivision 3a does not apply to the release of health records to the commissioner of health or the health data institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

[For text of subds 3c to 6, see M.S.1994]

History: *1995 c 205 art 2 s 3; 1995 c 234 art 5 s 23; 1995 c 259 art 1 s 34; art 4 s 5*

144.3351 IMMUNIZATION DATA.

Providers as defined in section 144.335, subdivision 1, group purchasers as defined in section 62J.03, subdivision 6, elementary or secondary schools or child care facilities as defined in section 123.70, subdivision 9, public or private post–secondary educational institutions as defined in section 135A.14, subdivision 1, paragraph (b), a board of health as defined in section 145A.02, subdivision 2, community action agencies as defined in section 268.53, subdivision 1, and the commissioner of health may exchange immunization data with one another, without the patient's consent, if the person requesting access provides services on behalf of the patient. For purposes of this section immunization data includes:

(1) patient's name, address, date of birth, gender, parent or guardian's name; and

(2) date vaccine was received, vaccine type, lot number, and manufacturer of all immunizations received by the patient, and whether there is a contraindication or an adverse reaction indication.

This section applies to all immunization data, regardless of when the immunization occurred.

History: *1995 c 259 art 1 s 35*

144.3831 FEES.

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of $5.21 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

[For text of subds 2 and 3, see M.S.1994]

History: *1995 c 186 s 42*

144.394 SMOKING PREVENTION.

The commissioner may sell at market value, all nonsmoking or tobacco use prevention advertising materials. Proceeds from the sale of the advertising materials are appropriated to the department of health for its nonsmoking program.

History: *1995 c 207 art 9 s 6*

144.401 COMMUNITY PREVENTION GRANTS.

[For text of subds 1 to 4, see M.S.1994]

Subd. 5. **Transfer of funds.** Federal money provided to the commissioner of children, families, and learning for community prevention grants through the federal Drug Free Schools and Communities Act is transferred to the commissioner of health for prevention grants under this section.

History: *1Sp1995 c 3 art 16 s 13*

144.414 PROHIBITIONS.

[For text of subds 1 and 2, see M.S.1994]

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, or other health care–related facility, other than a nursing home, boarding care facility, or licensed residential facility, except as allowed in this subdivision.

(b) Smoking by patients in a chemical dependency treatment program or mental health program may be allowed in a separated well–ventilated area pursuant to a policy established by the administrator of the program that identifies circumstances in which prohibiting smoking would interfere with the treatment of persons recovering from chemical dependency or mental illness.

(c) Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

History: *1995 c 165 s 2*

144.417 COMMISSIONER OF HEALTH, ENFORCEMENT, PENALTIES.

Subdivision 1. **Rules.** The state commissioner of health shall adopt rules necessary and reasonable to implement the provisions of sections 144.411 to 144.417, except as provided for in section 144.414.

[For text of subds 2 and 3, see M.S.1994]

History: *1995 c 165 s 3*

144.4172 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1994]

Subd. 8. **Health threat to others.** "Health threat to others" means that a carrier demonstrates an inability or unwillingness to act in such a manner as to not place others at risk of exposure to infection that causes serious illness, serious disability, or death. It includes one or more of the following:

(1) with respect to an indirectly transmitted communicable disease:

(a) behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others; or

(b) a substantial likelihood that a carrier will transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention.

(2) With respect to a directly transmitted communicable disease:

(a) repeated behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others;

(b) a substantial likelihood that a carrier will repeatedly transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention;

(c) affirmative misrepresentation by a carrier of the carrier's status prior to engaging in any behavior which has been demonstrated epidemiologically to transmit the disease; or

(d) the activities referenced in clause (1) if the person whom the carrier places at risk is: (i) a minor, (ii) of diminished capacity by reason of mood altering chemicals, including alcohol, (iii) has been diagnosed as having significantly subaverage intellectual functioning, (iv) has an organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation, or memory which substantially impairs judgment, behavior, reasoning, or understanding; (v) adjudicated as an incompetent; or (vi) a vulnerable adult as defined in section 626.5572.

(3) Violation by a carrier of any part of a court order issued pursuant to this chapter.

[For text of subds 9 to 11, see M.S.1994]

History: *1995 c 229 art 4 s 4*

144.56 STANDARDS.

[For text of subds 1 to 2a, see M.S.1994]

Subd. 2b. **Boarding care homes.** The commissioner shall not adopt or enforce any rule that limits a certified boarding care home from providing nursing services in accordance with the home's Medicaid certification.

[For text of subds 3 and 4, see M.S.1994]

History: *1995 c 207 art 7 s 6*

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

[For text of subd 1, see M.S.1994]

Subd. 2. **Eligibility for license condition.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as docu-

mented on the statistical reports to the department of health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66. Eligible hospitals are allowed a total of 1,460 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. The commissioner of health must approve swing bed use beyond 1,460 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital.

[For text of subds 3 to 7, see M.S.1994]

History: *1995 c 207 art 7 s 7*

144.6501 NURSING HOME ADMISSION CONTRACTS.

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

(a) "Facility" means a nursing home licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.58.

(b) "Contract of admission," "admission contract," or "admission agreement," includes, but is not limited to, all documents that a resident or resident's representative must sign at the time of, or as a condition of, admission to the facility. Oral representations and statements between the facility and the resident or resident's representative are not part of the contract of admission unless expressly contained in writing in those documents. The contract of admission must specify the obligations of the resident or the responsible party.

(c) "Legal representative" means an attorney–in–fact under a valid power of attorney executed by the prospective resident, or a conservator or guardian of the person or of the estate, or a representative payee appointed for the prospective resident, or other agent of limited powers.

(d) "Responsible party" means a person who has access to the resident's income and assets and who agrees to apply the resident's income and assets to pay for the resident's care or who agrees to make and complete an application for medical assistance on behalf of the resident.

[For text of subds 2 and 3, see M.S.1994]

Subd. 4. **Resident and facility obligations.** (a) Before or at the time of admission, the facility shall make reasonable efforts to communicate the content of the admission contract to, and obtain on the admission contract the signature of, the person who is to be admitted to the facility and the responsible party. The admission contract must be signed by the prospective resident unless the resident is legally incompetent or cannot understand or sign the admission contract because of the resident's medical condition.

(b) If the resident cannot sign the admission contract, the reason must be documented in the resident's medical record by the admitting physician.

(c) If the determination under paragraph (b) has been made, the facility may request the signature of another person on behalf of the applicant, subject to the provisions of paragraph (d). The facility must not require the person to disclose any information regarding the person's personal financial assets, liabilities, or income, unless the person voluntarily chooses to become financially responsible for the resident's care. The facility must issue timely billing, respond to questions, and monitor timely payment.

(d) A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so. A person other than the resident or a financially responsible spouse who signs an admission contract must not be required by the facility to assume personal financial liability for the resident's care. However, if the responsible party has signed the admission contract and fails to make timely payment of the facility obligation, or knowingly fails to spenddown the resident's assets appropriately for the purpose of obtaining medical assistance, then the responsible party shall be liable to the facility for the resident's costs of care which are not paid for by medical assistance. A responsible party shall be personally liable only to the extent the resident's income or assets were misapplied.

(e) The admission contract must include written notice in the signature block, in bold capital letters, that a person other than the resident or financially responsible spouse may not be required by the facility to assume personal financial liability for the resident's care.

(f) This subdivision does not preclude the facility from obtaining the signature of a legal representative, if applicable.

[For text of subds 5 to 10, see M.S.1994]

History: *1995 c 136 s 1,2*

SUBACUTE CARE WAIVERS

144.6505 SUBACUTE CARE WAIVERS.

Subdivision 1. **Subacute care; waiver from state and federal rules and regulations.** The commissioners of health and human services shall work with providers to examine state and federal rules and regulations governing the provision of care in nursing facilities and apply for federal waivers and pursue state law changes to any impediments to the provision of subacute care in skilled nursing facilities.

Subd. 2. **Definition of subacute care.** (a) For the purpose of this section, "subacute care" means comprehensive inpatient care, as further defined in this subdivision, designed for persons who:

(1) have or have had an acute illness or accident, or an acute exacerbation of a chronic illness, and who require a moderate level of service intensity;

(2) do not require, or no longer require, technologically intensive diagnosis or management;

(3) have concurrent medical, nursing, and discharge and/or nondischarge oriented rehabilitation objectives that are expected to be achieved within a specified time; and

(4) require interdisciplinary management.

(b) Subacute care includes goal–oriented treatment rendered immediately after, or as an appropriate alternative to, acute hospitalization with the goal of transitioning patients towards increased independence or lower acuity level in a cost–effective environment, to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a patient's underlying long–term conditions and overall situation.

(c) Subacute care does not generally depend heavily on high technology monitoring or complex diagnostic procedures.

(d) Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.

(e) Subacute care is provided as part of a specifically defined program.

(f) Subacute care includes more intensive care than traditional nursing facility care and less intensive care than acute care and may be provided at a variety of sites, including hospitals and skilled nursing facilities.

(g) Subacute care requires recurrent patient assessment on a daily to weekly basis and review of the clinical course and treatment plan for a limited time period ranging from several days to several months, until the condition is stabilized or a predetermined treatment course is completed.

History: *1995 c 207 art 7 s 8; 1995 c 263 s 14*

144.651 PATIENTS AND RESIDENTS OF HEALTH CARE FACILITIES; BILL OF RIGHTS.

[For text of subds 1 to 13, see M.S.1994]

Subd. 14. **Freedom from maltreatment.** Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce

mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self–injury or injury to others.

[For text of subds 15 to 20, see M.S.1994]

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

[For text of subds 22 to 25, see M.S.1994]

Subd. 26. **Right to associate.** Residents may meet with visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes the right to join with other individuals within and outside the facility to work for improvements in long–term care. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinionsof the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

[For text of subds 27 to 32, see M.S.1994]

History: *1995 c 136 s 3–4; 1995 c 229 art 4 s 5–6*

144.702 VOLUNTARY REPORTING OF HOSPITAL AND OUTPATIENT SURGICAL CENTER COSTS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Approval of organization's reporting procedures.** The commissioner of health may approve voluntary reporting procedures consistent with written operating requirements for the voluntary, nonprofit reporting organization which shall be established annually by the commissioner. These written operating requirements shall specify reports, analyses, and other deliverables to be produced by the voluntary, nonprofit reporting organization, and the dates on which those deliverables must be submitted to the commissioner. These written operating requirements shall specify deliverable dates sufficient to enable the commissioner of health to process and report health care cost information system data to the commissioner of human services by August 15 of each year. The commissioner of health

shall, by rule, prescribe standards for submission of data by hospitals and outpatient surgical centers to the voluntary, nonprofit reporting organization or to the commissioner. These standards shall provide for:

(a) The filing of appropriate financial information with the reporting organization;

(b) Adequate analysis and verification of that financial information; and

(c) Timely publication of the costs, revenues, and rates of individual hospitals and outpatient surgical centers prior to the effective date of any proposed rate increase. The commissioner of health shall annually review the procedures approved pursuant to this subdivision.

[For text of subds 3 to 8, see M.S.1994]

History: *1995 c 207 art 6 s 3*

144.801 DEFINITIONS.

[For text of subds 1 and 2, see M.S.1994]

Subd. 3. **Board.** "Board" means the emergency medical services regulatory board.

[For text of subd 4, see M.S.1994]

Subd. 5. **License.** "License" means authority granted by the board for the operation of an ambulance service in the state of Minnesota.

[For text of subds 6 to 10, see M.S.1994]

Subd. 11. **First responder.** "First responder" means an individual who is certified by the commissioner to perform, at a minimum, basic emergency skills before the arrival of a licensed ambulance service, and is:

(1) a member of an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service; or

(2) a member of an organized industrial medical first response team.

History: *1995 c 207 art 9 s 7,8; 1995 c 234 art 8 s 44*

144.802 LICENSING.

Subdivision 1. **Licenses; contents, changes, and transfers.** No natural person, partnership, association, corporation or unit of government may operate an ambulance service within this state unless it possesses a valid license to do so issued by the board. The license shall specify the base of operations, primary service area, and the type or types of ambulance service for which the licensee is licensed. The licensee shall obtain a new license if it wishes to establish a new base of operation, or to expand its primary service area, or to provide a new type or types of service. A license, or the ownership of a licensed ambulance service, may be transferred only after the approval of the board, based upon a finding that the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of section 144.804. If the proposed transfer would result in a change in or addition of a new base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service, the board shall require the prospective licensee or owner to comply with subdivision 3. The board may approve the license or ownership transfer prior to completion of the application process described in subdivision 3 upon obtaining written assurances from the proposed licensee or proposed new owner that no change in the service's base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service will occur during the processing of the application. The cost of licenses shall be in an amount prescribed by the board pursuant to section 144.122. Licenses shall expire and be renewed as prescribed by the board pursuant to section 144.122. Fees collected shall be deposited to the trunk highway fund.

Subd. 2. **Requirements for new licenses.** The board shall not issue a license authorizing the operation of a new ambulance service, provision of a new type or types of ambulance service by an existing service, or establishment of a new base of operation or an expanded

primary service area for an existing service unless the requirements of sections 144.801 to 144.807 are met.

Subd. 3. **Applications; notice of application; recommendations.** (a) Each prospective licensee and each present licensee wishing to offer a new type or types of ambulance service, to establish a new base of operation, or to expand a primary service area, shall make written application for a license to the board on a form provided by the board.

(b) The board shall review the application for completeness, clarity, and content.

(c) For applications for the provision of ambulance services in a service area located within a county, the board shall promptly send notice of the completed application to the county board and to each community health board, governing body of a regional emergency medical services system designated under section 144.8093, ambulance service, and municipality in the area in which ambulance service would be provided by the applicant. The board shall publish the notice, at the applicant's expense, in the State Register and in a newspaper in the municipality in which the base of operation will be located, or if no newspaper is published in the municipality or if the service would be provided in more than one municipality, in a newspaper published at the county seat of the county in which the service would be provided.

(d) For applications for the provision of ambulance services in a service area larger than a county, the board shall promptly send notice of the completed application to the municipality in which the service's base of operation will be located and to each community health board, county board, governing body of a regional emergency medical services system designated under section 144.8093, and ambulance service located within the counties in which any part of the service area described by the applicant is located, and any contiguous counties. The board shall publish this notice, at the applicant's expense, in the State Register.

(e) Within 30 days of receiving a completed application, the board shall forward the application, along with any recommendations regarding the application, and shall request that the chief administrative law judge appoint an administrative law judge to hold a public hearing in the municipality in which the service's base of operation will be located. The public hearing shall be conducted as contested case hearing under chapter 14.

(f) Each municipality, county, community health board, governing body of a regional emergency medical services system, ambulance service, and other person wishing to make recommendations concerning the disposition of the application shall make written recommendations to the administrative law judge within 30 days of the publication of notice of the application in the State Register.

(g) The administrative law judge shall:

(1) hold a public hearing in the municipality in which the service's base of operations is or will be located;

(2) provide notice of the public hearing in the newspaper or newspapers in which notice was published under paragraph (b) for two successive weeks at least ten days before the date of the hearing;

(3) allow any interested person the opportunity to be heard, to be represented by counsel, and to present oral and written evidence at the public hearing;

(4) provide a transcript of the hearing at the expense of any individual requesting it; and

(5) consider and make part of the public record the recommendations of the board.

(h) The administrative law judge shall review the application and shall forward a decision and order as to its disposition to the board within 90 days of receiving notice of the application. In making the decision, the administrative law judge shall consider and make written comments as to whether the proposed service, change in base of operations, or expansion in primary service area is needed, based on consideration of the following factors:

(1) the relationship of the proposed service, change in base of operations or expansion in primary service area to the current community health plan as approved by the commissioner of health under section 145A.12, subdivision 4;

(2) the recommendations or comments of the governing bodies of the counties, municipalities, and regional emergency medical services system designated under section 144.8093 in which the service would be provided;

(3) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;

(4) the estimated effect of the proposed service, change in base of operation or expansion in primary service area on the public health;

(5) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, change in base of operations, or expansion in primary service area.

The administrative law judge shall order the board to grant or deny a license or order that a modified license be granted. The reasons for the order shall be set forth in detail. The administrative law judge shall make the order and reasons available to any individual requesting them.

Subd. 3a. **Licensure of air ambulance services.** Except for submission of a written application to the board on a form provided by the board, an application to provide air ambulance service shall be exempt from the provisions of subdivisions 3 and 4.

A license issued pursuant to this subdivision need not designate a primary service area.

No license shall be issued under this subdivision unless the board determines that the applicant complies with the requirements of applicable federal and state statutes and rules governing aviation operations within the state.

Subd. 3b. **Summary approval of primary service areas.** Except for submission of a written application to the board on a form provided by the board, an application to provide changes in a primary service area shall be exempt from subdivisions 3, paragraphs (d) to (g); and 4, if:

(1) the application is for a change of primary service area to improve coverage, to improve coordination with 911 emergency dispatching, or to improve efficiency of operations;

(2) the application requests redefinition of contiguous or overlapping primary service areas;

(3) the application shows approval from the ambulance licensees whose primary service areas are directly affected by a change in the applicant's primary service area;

(4) the application shows that the applicant requested review and comment on the application, and has included those comments received from: all county boards in the areas of coverage included in the application; all community health boards in the areas of coverage included in the application; all directors of 911 public safety answering point areas in the areas of coverage included in the application; and all regional emergency medical systems areas designated under section 144.8093 in the areas of coverage included in the application; and

(5) the application shows consideration of the factors listed in subdivision 3, paragraph (g).

Subd. 4. **Issuance of license.** Within 30 days after receiving the administrative law judge's order, the board shall grant or deny a license to the applicant.

Subd. 5. **Contested cases.** The board's decision made under subdivision 3a or the administrative law judge's decision under subdivision 3 shall be the final administrative decision. Any person aggrieved by the board's decision or action shall be entitled to judicial review in the manner provided in sections 14.63 to 14.69.

Subd. 6. **Temporary license.** Notwithstanding other provisions herein, the board may issue a temporary license for instances in which a primary service area would be deprived of ambulance service. The temporary license shall expire when an applicant has been issued a regular license under this section. The temporary license shall be valid no more than six months from date of issuance. A temporary licensee must provide evidence that the licensee will meet the requirements of section 144.804 and the rules adopted under this section.

History: *1995 c 207 art 9 s 9*

144.803 LICENSING; SUSPENSION AND REVOCATION.

The board may initiate a contested case hearing upon reasonable notice to suspend, revoke, or refuse to renew the license of a licensee upon finding that the licensee has violated sections 144.801 to 144.808 or has ceased to provide the service for which it is licensed. The

decision of the administrative law judge in the contested case hearing shall be the decision of the board.

History: *1995 c 207 art 9 s 10*

144.804 STANDARDS.

Subdivision 1. **Drivers and attendants.** No publicly or privately owned basic ambulance service shall be operated in the state unless its drivers and attendants possess a current emergency care course certificate authorized by rules adopted by the board according to chapter 14. Until August 1, 1997, a licensee may substitute a person currently certified by the American Red Cross in advanced first aid and emergency care or a person who has successfully completed the United States Department of Transportation first responder curriculum, and who has also been trained to use basic life support equipment as required by rules adopted by the board under section 144.804, subdivision 3, for one of the persons on a basic ambulance, provided that person will function as the driver while transporting a patient. The board may grant a variance to allow a licensed ambulance service to use attendants certified by the American Red Cross in advanced first aid and emergency care and, until August 1, 1997, to use attendants who have successfully completed the United States Department of Transportation first responder curriculum, and who have been trained to use basic life support equipment as required by rules adopted by the commissioner under subdivision 3, in order to ensure 24–hour emergency ambulance coverage.

Subd. 2. **Equipment and staff.** (a) Every ambulance offering ambulance service shall be equipped as required by the board and carry at least the minimal equipment necessary for the type of service to be provided as determined by standards adopted by the board pursuant to subdivision 3.

(b) Each ambulance service shall offer service 24 hours per day every day of the year, unless otherwise authorized by the board.

(c) Each ambulance while transporting a patient shall be staffed by at least a driver and an attendant, according to subdivision 1. An ambulance service may substitute for the attendant a physician, osteopath, registered nurse, or physician's assistant who is qualified by training to use appropriate equipment in the ambulance. Advanced life support procedures including, but not limited to, intravenous fluid administration, drug administration, endotracheal intubation, cardioversion, defibrillation, and intravenous access may be performed by the physician, osteopath, registered nurse, or physician's assistant who has appropriate training and authorization, and who provides all of the equipment and supplies not normally carried on basic ambulances.

(d) An ambulance service shall not deny emergency ambulance service to any person needing emergency ambulance service because of inability to pay or due to source of payment for services if this need develops within the licensee's primary service area. Transport for such a patient may be limited to the closest appropriate emergency medical facility.

Subd. 3. **Types of services to be regulated.** The board may adopt rules needed to carry out sections 144.801 to 144.8091, including the following types of ambulance service:

(a) basic ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to rules adopted by the board according to chapter 14, and that provides a level of care so as to ensure that life–threatening situations and potentially serious injuries can be recognized, patients will be protected from additional hazards, basic treatment to reduce the seriousness of emergency situations will be administered and patients transported to an appropriate medical facility for treatment;

(b) intermediate ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the board adopts according to chapter 14, and that provides basic ambulance service and intravenous infusions or defibrillation or both. Standards adopted by the commissioner shall include, but not be limited to, equipment, training, procedures, and medical control;

(c) advanced ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the board adopts according to chapter 14, and that provides basic ambulance service, and in addition, advanced airway management, defibrillation, and administration of intravenous fluids and pharmaceuticals. Vehicles of ad-

vanced ambulance service licensees not equipped or staffed at the advanced ambulance service level shall not be identified to the public as capable of providing advanced ambulance service.

(d) specialized ambulance service that provides basic, intermediate, or advanced service as designated by the board, and is restricted by the board to (1) less than 24 hours of every day, (2) designated segments of the population, or (3) certain types of medical conditions; and

(e) air ambulance service, that includes fixed–wing and helicopter, and is specialized ambulance service.

Until standards have been developed under clauses (b), (d), and (e), the current provisions of Minnesota Rules shall govern these services.

Subd. 5. **Local government's powers.** Local units of government may, with the approval of the board, establish standards for ambulance services which impose additional requirements upon such services. Local units of government intending to impose additional requirements shall consider whether any benefit accruing to the public health would outweigh the costs associated with the additional requirements. Local units of government which desire to impose such additional requirements shall, prior to promulgation of relevant ordinances, rules or regulations, furnish the board with a copy of such proposed ordinances, rules or regulations, along with information which affirmatively substantiates that the proposed ordinances, rules or regulations: will in no way conflict with the relevant rules of the department of health; will establish additional requirements tending to protect the public health; will not diminish public access to ambulance services of acceptable quality; and will not interfere with the orderly development of regional systems of emergency medical care. The board shall base any decision to approve or disapprove such standards upon whether or not the local unit of government in question has affirmatively substantiated that the proposed ordinances, rules or regulations meet these criteria.

Subd. 6. **Rules on primary service areas.** The board shall promulgate rules defining primary service areas under section 144.801, subdivision 8, under which the board shall designate each licensed ambulance service as serving a primary service area or areas.

Subd. 7. **Drivers of ambulances.** An ambulance service vehicle shall be staffed by a driver possessing a current Minnesota driver's license or equivalent and whose driving privileges are not under suspension or revocation by any state. If red lights and siren are used, the driver must also have completed training approved by the board in emergency driving techniques. An ambulance transporting patients must be staffed by at least two persons who are trained according to subdivision 1, or section 144.809, one of whom may be the driver. A third person serving as driver shall be trained according to this subdivision.

History: *1995 c 207 art 9 s 11; 1995 c 234 art 8 s 45*

144.806 PENALTIES.

Any person who violates a provision of sections 144.801 to 144.806 is guilty of a misdemeanor. The board may issue fines to assure compliance with sections 144.801 to 144.806 and rules adopted under those sections. The board shall adopt rules to implement a schedule of fines by January 1, 1991.

History: *1995 c 207 art 9 s 12*

144.807 REPORTS.

Subdivision 1. **Reporting of information.** Operators of ambulance services licensed pursuant to sections 144.801 to 144.806 shall report information about ambulance service to the board as the board may require. The reports shall be classified as "private data on individuals" under the Minnesota government data practices act, chapter 13.

Subd. 2. **Failure to report.** Failure to report all information required by the board shall constitute grounds for licensure revocation.

History: *1995 c 207 art 9 s 13*

144.808 INSPECTIONS.

The board may inspect ambulance services as frequently as deemed necessary. These inspections shall be for the purpose of determining whether the ambulance and equipment is

clean and in proper working order and whether the operator is in compliance with sections 144.801 to 144.804 and any rules that the board adopts related to sections 144.801 to 144.804.

History: *1995 c 207 art 9 s 14*

144.809 RENEWAL OF BASIC EMERGENCY CARE COURSE CERTIFICATE; FEE.

Subdivision 1. **Standards for recertification.** The board shall adopt rules establishing minimum standards for expiration and recertification of basic emergency care course certificates. These standards shall require:

(1) four years after initial certification, and every four years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which must be approved by the board; and

(2) two years after initial certification, and every four years thereafter, in-service continuing education, including knowledge and skill proficiency testing, all of which must be conducted under the supervision of a medical director or medical advisor and approved by the board.

Course requirements under clause (1) shall not exceed 24 hours. Course requirements under clause (2) shall not exceed 36 hours, of which at least 12 hours may consist of course material developed by the medical director or medical advisor.

Individuals may choose to complete, two years after initial certification, and every two years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which are approved by the board, in lieu of completing requirements in clauses (1) and (2).

Subd. 2. **Upgrading to basic emergency care course certificate.** The board shall adopt rules authorizing the equivalence of the following as credit toward successful completion of the board's basic emergency care course:

(1) successful completion of the United States Department of Transportation first responder curriculum;

(2) a minimum of two years of documented continuous service as an ambulance driver, as authorized in section 144.804, subdivision 7;

(3) documented clinical experience obtained through work or volunteer activity as a first responder; and

(4) documented continuing education in emergency care.

Subd. 3. **Limitation on fees.** No fee set by the board for biennial renewal of a basic emergency care course certificate by a volunteer member of an ambulance service, fire department, or police department shall exceed $2.

History: *1995 c 207 art 9 s 15*

144.8091 REIMBURSEMENT TO NONPROFIT AMBULANCE SERVICES.

Subdivision 1. **Repayment for volunteer training.** Any political subdivision, or nonprofit hospital or nonprofit corporation operating a licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency care course, or a continuing education course for basic emergency care, or both, which has been approved by the board, pursuant to section 144.804. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than $450 for successful completion of a basic course, and $225 for successful completion of a continuing education course.

Subd. 2. **Volunteer attendant defined.** For purposes of this section, "volunteer ambulance attendant" means a person who provides emergency medical services for a Minnesota licensed ambulance service without the expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though that individual receives

an hourly stipend for each hour of actual service provided, except for hours on standby alert, even though this hourly stipend is regarded as taxable income for purposes of state or federal law, provided that this hourly stipend does not exceed $3,000 within one year of the final certification examination. Reimbursement will be paid under provisions of this section when documentation is provided the board that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

History: *1995 c 207 art 9 s 16*

144.8093 EMERGENCY MEDICAL SERVICES FUND.

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

Subd. 2. **Establishment and purpose.** In order to develop, maintain, and improve regional emergency medical services systems, the emergency medical services regulatory board shall establish an emergency medical services system fund. The fund shall be used for the general purposes of promoting systematic, cost–effective delivery of emergency medical care throughout the state; identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs; providing discretionary grants for emergency medical service projects with potential regionwide significance; providing for public education about emergency medical care; promoting the exchange of emergency medical care information; ensuring the ongoing coordination of regional emergency medical services systems; and establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

Subd. 2a. **Definition.** For purposes of this section, "board" means the emergency medical services regulatory board.

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

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

History: *1995 c 207 art 9 s 17*

144.8095 FUNDING FOR THE EMERGENCY MEDICAL SERVICES REGIONS.

The emergency medical services regulatory board shall distribute funds appropriated from the general fund equally among the emergency medical service regions. Each regional board may use this money to reimburse eligible emergency medical services personnel for continuing education costs related to emergency care that are personally incurred and are not

reimbursed from other sources. Eligible emergency medical services personnel include, but are not limited to, dispatchers, emergency room physicians, emergency room nurses, first responders, emergency medical technicians, and paramedics.

History: *1995 c 207 art 9 s 18*

144.8097 EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL.

[For text of subds 1 and 2, see M.S. 1994]

NOTE: This section is repealed by Laws 1995, chapter 207, article 9, section 61, subdivision 2, effective July 1, 1996.

144.871 [Repealed, 1995 c 213 art 1 s 13]

144.872 [Repealed, 1995 c 213 art 1 s 13]

144.873 [Repealed, 1995 c 213 art 1 s 13]

144.874 [Repealed, 1995 c 213 art 1 s 13]

144.876 [Repealed, 1995 c 213 art 1 s 13]

144.877 Subdivision 1. [Repealed, 1995 c 213 art 1 s 13]
Subd. 2. [Repealed, 1995 c 213 art 1 s 13]
Subd. 3. [Repealed, 1995 c 213 art 1 s 13]
Subd. 4. [Repealed, 1995 c 213 art 1 s 13]
Subd. 5. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]
Subd. 6. [Repealed, 1995 c 213 art 1 s 13]
Subd. 7. [Repealed, 1995 c 213 art 1 s 13]

144.8771 [Repealed, 1995 c 213 art 1 s 13]

144.878 [Repealed, 1995 c 213 art 1 s 13]

144.8781 ENFORCEMENT.

Subd. 4. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]
Subd. 6. [Repealed, 1995 c 213 art 1 s 13]

144.8782 [Repealed, 1995 c 213 art 1 s 13]

144.879 [Repealed, 1995 c 213 art 1 s 13]

CHILDHOOD LEAD POISONING ACT

144.9501 DEFINITIONS.

Subdivision 1. **Citation.** Sections 144.9501 to 144.9509 may be cited as the "childhood lead poisoning act."

Subd. 2. **Applicability.** The definitions in this section apply to sections 144.9501 to 144.9509.

Subd. 3. **Abatement.** (a) "Abatement" means any set of measures designed to permanently eliminate lead–based paint hazards, defined in United States Code, title 42, section 4851, of the federal Housing and Community Development Act of 1992, and that exceed the standards adopted under section 144.9508. Abatement includes:

(1) the removal of lead–based paint and lead–contaminated dust, the permanent containment or encapsulation of lead–based paint, the replacement of lead–painted surfaces or fixtures, and the removal or covering of lead–contaminated soil; and

(2) all preparation, cleanup, disposal, and postabatement clearance testing activities associated with these measures.

(b) Abatement does not include:

(1) activities such as remodeling, renovation, installation, rehabilitation, or landscaping activities whose primary intent is to remodel, repair, or restore a given structure or dwelling,

rather than to permanently eliminate lead–based paint hazards, even though these activities may incidentally result in a reduction in lead–based paint hazards; and

(2) interim controls for the temporary reduction of exposure to lead hazards such as lead–specific cleaning, repairs, maintenance, painting, and temporary containment.

Subd. 4. **Areas at high risk for toxic lead exposure.** "Areas at high risk for toxic lead exposure" means a census tract which meets one or more of the following criteria:

(1) elevated blood lead levels have been diagnosed in a population of children or pregnant females;

(2) many residential structures that are known to have or suspected of having deteriorated lead–based paint; or

(3) median soil lead concentrations are greater than 100 parts per million for samples collected according to rules adopted under section 144.9508.

Subd. 5. **Bare soil.** "Bare soil" means any visible soil that is at least an area of 36 contiguous square inches.

Subd. 6. **Board of health.** "Board of health" means an administrative authority established under section 145A.03.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of the Minnesota department of health.

Subd. 8. **Deteriorated paint.** "Deteriorated paint" means paint that is chipped, peeled, or otherwise separated from its substrate or that is attached to damaged substrate.

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ten micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

Subd. 10. **Encapsulation.** "Encapsulation" means covering a surface coated with paint that exceeds the standards under section 144.9508 with a liquid or solid material, approved by the commissioner, that adheres to the surface, rather than mechanically attaches to it; or covering bare soil that exceeds the standards under section 144.9508 with a permeable material such as vegetation, mulch, or soil that meets the standards under section 144.9508.

Subd. 11. **Enclosure.** "Enclosure" means covering a surface coated with paint that exceeds the standards under section 144.9508 by mechanically fastening to the surface a durable, solid material approved by the commissioner; or covering bare soil that exceeds the standards under section 144.9508 with an impermeable material, such as asphalt or concrete.

Subd. 12. **Inspecting agency.** "Inspecting agency" means the commissioner or a board of health.

Subd. 13. **Intact paint.** "Intact paint" means paint that is not chipped, peeled, or otherwise separated from its substrate or attached to damaged substrate. Painted surfaces which may generate dust but are not chipped, peeled, or otherwise separated from their substrate or attached to damaged substrate are considered to be intact paint.

Subd. 14. **Lead contractor.** "Lead contractor" means any person who is licensed by the commissioner under section 144.9505.

Subd. 15. **Lead hazard.** "Lead hazard" means a condition that causes exposure to lead from dust, bare soil, drinking water, or deteriorated paint that exceeds the standards adopted under section 144.9508.

Subd. 16. **Lead hazard management.** "Lead hazard management" means a process by which a residence is made lead–safe through the use of lead–safe directives provided for under section 144.9503.

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means action undertaken in response to a lead order to make a residence, child care facility, school, or playground lead–safe by complying with the lead standards and methods adopted under section 144.9508, by:

(1) a property owner or lead contractor complying with a lead order issued under section 144.9504; or

(2) a swab team service provided in response to a lead order issued under section 144.9504.

Subd. 18. **Lead inspection.** "Lead inspection" means a qualitative or quantitative analytical inspection of a residence for deteriorated paint or bare soil and the collection of samples of deteriorated paint, bare soil, dust, or drinking water for analysis to determine if the lead concentrations in the samples exceed standards adopted under section 144.9508. Lead inspection includes the clearance inspection after the completion of a lead order.

Subd. 19. **Lead inspector.** "Lead inspector" means a person who is licensed by the commissioner to perform a lead inspection under section 144.9506.

Subd. 20. **Lead order.** "Lead order" means a legal instrument to compel a property owner to engage in lead hazard reduction according to the specifications given by the inspecting agency.

Subd. 21. **Lead–safe.** "Lead–safe" means a condition in which lead may be present at the residence, child care facility, school, or playground, if the lead concentration in the dust, paint, soil, and water of a residence does not exceed the standards adopted under section 144.9508, or, if the lead concentrations in the paint or soil do exceed the standards, the paint is intact and the soil is not bare.

Subd. 22. **Lead–safe directives.** "Lead–safe directives" means methods for construction, renovation, remodeling, or maintenance activities that are not regulated as abatement or lead hazard reduction and that are performed so that they do not:

(1) violate the standards under section 144.9508;

(2) create lead dust through the use of prohibited practices;

(3) leave debris or a lead residue that can form a dust;

(4) provide a readily accessible source of lead dust, lead paint, lead paint chips, or lead contaminated soil, after the use of containment methods; and

(5) result in improper disposal of lead contaminated debris, dust, or soil.

Subd. 23. **Lead worker.** "Lead worker" means any person who is certified by the commissioner under section 144.9505.

Subd. 24. **Person.** "Person" has the meaning given in section 326.71, subdivision 8.

Subd. 25. **Persons at high risk for elevated blood lead level.** "Persons at high risk for elevated blood lead level" means:

(1) a child between six and 72 months of age:

(a) who lives in or visits, at least weekly, a residence, child care facility, or school built before 1978 which has peeling or chipping paint, ongoing remodeling or renovation, or bare soil; or

(b) who has a sibling, housemate, or playmate who has been diagnosed with an elevated blood lead level in the last 12 months; and

(2) a pregnant female or a child between six and 72 months of age:

(a) who lives in a census tract found to have a median foundation soil lead value exceeding 100 parts per million of lead;

(b) who lives near an industrial point source that emits lead;

(c) who lives near a road with an average daily traffic which exceeded 5,000 vehicles per day in 1986 or earlier; or

(d) who lives with a person whose occupation or hobby involves exposure to lead.

Subd. 26. **Primary prevention.** "Primary prevention" means preventing toxic lead exposure before blood levels become elevated.

Subd. 27. **Safe housing.** "Safe housing" means a residence that is lead–safe.

Subd. 28. **Secondary prevention.** "Secondary prevention" means intervention to mitigate health effects on people with elevated blood lead levels.

Subd. 29. **Swab team services.** "Swab team services" means activities that provide protection from lead hazards such as:

(1) removing lead dust by washing, vacuuming with high efficiency particle accumulator (HEPA) or wet vacuum cleaners, and cleaning the interior of residential property;

(2) removing loose paint and paint chips and reporting or installing guards to protect intact paint;

(3) covering or replacing bare soil that has a lead concentration of 100 parts per million or more;

(4) health education;

(5) advice and assistance to help residents locate and move to a temporary residence while lead hazard reduction is being completed; or

(6) any other assistance necessary to meet the resident's immediate needs as a result of the relocation.

Subd. 30. **Swab team worker.** "Swab team worker" means a person who is certified under section 144.9505.

Subd. 31. **Venous blood sample.** "Venous blood sample" means a quantity of blood drawn from a vein.

Subd. 32. **Voluntary lead hazard reduction.** "Voluntary lead hazard reduction" means action undertaken by a property owner with the intention to engage in lead hazard reduction or abatement, but not in response to the issuance of a lead order.

History: *1995 c 213 art 1 s 3*

144.9502 LEAD SURVEILLANCE AND THE OCCURRENCE OF LEAD IN THE ENVIRONMENT.

Subdivision 1. **Surveillance.** The commissioner of health shall establish a statewide lead surveillance system. The purpose of this system is to:

(a) monitor blood lead levels in children and adults to identify trends and populations at high risk for elevated blood lead levels;

(b) ensure that screening services are provided to populations at high risk for elevated blood lead levels;

(c) ensure that medical and environmental follow–up services for children with elevated blood lead levels are provided; and

(d) provide accurate and complete data for planning and implementing primary prevention programs that focus on the populations at high risk for elevated blood lead levels.

Subd. 2. **Studies and surveys.** The commissioner of health shall collect blood lead level and exposure information, analyze the information, and conduct studies designed to determine the potential for high risk for elevated blood lead levels among children and adults.

Subd. 3. **Reports of blood lead analysis required.** Every hospital, medical clinic, medical laboratory, or other facility performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission, for a capillary or venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

The reporting requirements of this subdivision shall expire on December 31, 1997. Beginning January 1, 1998, every hospital, medical clinic, medical laboratory, or other facility performing blood lead analysis shall report the results within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for capillary or venous blood lead level equal to the level for which reporting is recommended by the Center for Disease Control.

Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis reports required in this section must specify:

(1) whether the specimen was collected as a capillary or venous sample;

(2) the date the sample was collected;

(3) the results of the blood lead analysis;

(4) the date the sample was analyzed;

(5) the method of analysis used;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the physician or facility requesting the analysis;

(8) the full name, address, and phone number of the person with the elevated blood lead level, and the person's birthdate, gender, and race.

Subd. 5. **Follow–up epidemiologic information.** The follow–up epidemiologic information required in this section must specify:

(1) the name, address, and phone number of the agency or individual contacted to investigate the environment of the person with the elevated blood lead level to determine the sources of lead exposure; and

(2) the name, address, and phone number of all agencies or individuals to whom the person or the person's guardian was referred for education about the sources, effects, and prevention of lead exposure.

Subd. 6. **Paint, soil, dust, and drinking water lead analysis.** Every laboratory or other institution performing lead analysis on paint, soil, dust, or drinking water shall report the results to the commissioner of each specimen analysis and epidemiologic information required in this section. The paint, soil, dust, and drinking water analysis report must specify:

(1) the date the sample was collected;

(2) the type of sample tested;

(3) the results of the lead sample analysis;

(4) the method of analysis used;

(5) the date the sample was analyzed;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the individual or agency requesting the analysis; and

(8) the address of the property and the owner of the property where the sample was collected.

Subd. 7. **Reporting without liability.** The furnishing of the information required under this section shall not subject the person, laboratory, or other facility furnishing the information to any action for damages or relief.

Subd. 8. **Laboratory standards.** (a) A laboratory performing blood lead analysis shall use methods that:

(1) meet or exceed the proficiency standards established in the federal Clinical Laboratory Improvement Regulations, Code of Federal Regulations, title 42, section 493, promulgated in accordance with the Clinical Laboratory Improvement Act amendments of 1988, Public Law Number 100–578; or

(2) meet or exceed the Occupational Safety and Health Standards for Lead in General Industries, Code of Federal Regulations, section 1910.1025, and Occupational Safety and Health Standards for Lead in Construction, Code of Federal Regulations, section 1926.62.

(b) A laboratory performing lead analysis of paint, soil, dust, or drinking water shall use methods that meet or exceed the proficiency standards established in the National Lead Accreditation Program pursuant to United States Code, title 42, section 4851, of the federal Housing and Community Development Act.

Subd. 9. **Classification of data.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected by the commissioner of health about persons with elevated blood lead levels, including analytic results from samples of paint, soil, dust, and drinking water taken from the individual's home and immediate property, shall be private and may only be used by the commissioner of health and authorized employees of local boards of health for the purposes set forth in this section.

History: *1995 c 213 art 1 s 4*

144.9503 PRIMARY PREVENTION.

Subdivision 1. **Primary prevention program.** The commissioner shall develop a primary prevention program to reduce lead exposure in young children and pregnant women. The commissioner shall develop a priority list for high risk census tracts, provide primary prevention lead education, promote primary prevention swab team services in cooperation with the commissioner of economic security or housing finance, provide lead cleanup equipment and material grants, monitor voluntary lead hazard reduction or abatement, and develop lead-safe directives in cooperation with the commissioner of administration.

Subd. 2. **Priorities for primary prevention.** The commissioner of health shall publish in the State Register a priority list of census tracts at high risk for toxic lead exposure. All local governmental units and boards of health shall follow the priorities published in the State Register. In establishing the list, the commissioner shall use the surveillance data collected under section 144.9502 and other information as appropriate or specified in this section and shall award points to each census tract on which information is available. The priority for primary prevention in census tracts at high risk for toxic lead exposure shall be based on the cumulative points awarded to each census tract. A greater number of points means a higher priority. If a tie occurs in the number of points, priority shall be given to the census tract with the higher percentage of population with blood lead levels greater than ten micrograms of lead per deciliter of whole blood. The commissioner shall revise and update the priority list at least every five years. Points shall be awarded as specified in paragraphs (a) to (c).

(a) In a census tract where at least 20 children have been screened in the last five years, one point shall be awarded for each ten percent of children who were under six years old at the time they were screened for lead in blood and whose blood lead level exceeds ten micrograms of lead per deciliter of whole blood. An additional point shall be awarded if one percent of the children had blood lead levels greater than 20 micrograms of lead per deciliter of blood. Two points shall be awarded to a census tract, where the blood lead screening has been inadequate, that is contiguous with a census tract where more than ten percent of the children under six years of age have blood lead levels exceeding ten micrograms of lead per deciliter of whole blood.

(b) One point shall be awarded for every five percent of housing that is defined as dilapidated or deteriorated by the planning department or similar agency of the city in which the housing is located. Where data is available by neighborhood or section within a city, the percent of dilapidated or deteriorated housing shall apply equally to each census tract within the neighborhood or section.

(c) One point shall be awarded for every 100 parts per million of lead soil, based on the median soil lead values of foundation soil samples, calculated on 100 parts per million intervals, or fraction thereof. For the cities of St. Paul and Minneapolis, the commissioner shall use the June 1988 census tract version of the houseside map titled "Distribution of Houseside Lead Content of Soil-Dust in the Twin Cities," prepared by the Center for Urban and Regional Affairs, Humphrey Institute, University of Minnesota, Publication 1989, Center for Urban and Regional Affairs 89-4. Where the map displays a census tract that is crossed by two or more intervals, the commissioner shall make a reasoned determination of the median foundation soil lead value for that census tract. Values for census tracts may be updated by surveying the census tract according to the procedures adopted under this section.

Subd. 3. **Primary prevention lead education strategy.** The commissioner of health shall develop a primary prevention lead education strategy to prevent lead exposure. The strategy shall specify:

(1) the development of lead education materials that describe the health effects of lead exposure, safety measures, and methods to be used in the lead hazard reduction process;

(2) the provision of lead education materials to the general public;

(3) the provision of lead education materials to property owners, landlords, and tenants by swab team workers and public health professionals, such as nurses, sanitarians, health educators, other public health professionals in areas at high risk for toxic lead exposure; and

(4) the promotion of awareness of community, legal, and housing resources.

Subd. 4. **Swab team services.** Primary prevention must include the use of swab team services in census tracts identified at high risk for toxic lead exposure as identified by the commissioner under this section. The swab team services may be provided based on visual inspections whenever possible and must at least include lead hazard management for deteriorated interior lead–based paint, bare soil, and dust.

Subd. 5. **Lead cleanup equipment and material grants.** (a) Nonprofit community–based organizations in areas at high risk for toxic lead exposure, as determined by the commissioner under this section, may apply for grants from the commissioner to purchase lead cleanup equipment and materials and to pay for training for staff and volunteers for lead certification.

(b) For the purposes of this section, lead cleanup equipment and materials means high efficiency particle accumulator (HEPA) and wet vacuum cleaners, wash water filters, mops, buckets, hoses, sponges, protective clothing, drop cloths, wet scraping equipment, secure containers, dust and particle containment material, and other cleanup and containment materials to remove loose paint and plaster, patch plaster, control household dust, wax floors, clean carpets and sidewalks, and cover bare soil.

(c) The grantee's staff and volunteers may make lead cleanup equipment and materials available to residents and property owners and instruct them on the proper use of the equipment. Lead cleanup equipment and materials must be made available to low–income households, as defined by federal guidelines, on a priority basis at no fee, and other households on a sliding fee scale.

(d) The grantee shall not charge a fee for services performed using the equipment or materials.

Subd. 6. **Voluntary lead hazard reduction.** The commissioner shall monitor the lead hazard reduction methods adopted under section 144.9508 in cases of voluntary lead hazard reduction. All contractors hired to do voluntary lead hazard reduction must be licensed lead contractors. If a property owner does not use a lead contractor for voluntary lead hazard reduction, the property owner shall provide the commissioner with a plan for lead hazard reduction at least ten working days before beginning the lead hazard reduction. The plan must include the details required in section 144.9505, and notice as to when lead hazard reduction activities will begin. No penalty shall be assessed against a property owner for discontinuing voluntary lead hazard reduction before completion of the plan, provided that the property owner discontinues the plan in a manner that leaves the property in a condition no more hazardous than its condition before the plan implementation.

Subd. 7. **Lead–safe directives.** By July 1, 1995, and amended and updated as necessary, the commissioner shall develop in cooperation with the commissioner of administration provisions and procedures to define lead–safe directives for residential remodeling, renovation, installation, and rehabilitation activities that are not lead hazard reduction, but may disrupt lead–based paint surfaces. The provisions and procedures shall define lead–safe directives for nonlead hazard reduction activities including preparation, cleanup, and disposal procedures. The directives shall be based on the different levels and types of work involved and the potential for lead hazards. The directives shall address activities including painting; remodeling; weatherization; installation of cable, wire, plumbing, and gas; and replacement of doors and windows. The commissioners of health and administration shall consult with representatives of builders, weatherization providers, nonprofit rehabilitation organizations, each of the affected trades, and housing and redevelopment authorities in developing the directives and procedures. This group shall also make recommendations for consumer and contractor education and training. The commissioner of health shall report to the legislature by February 15, 1996, regarding development of the provisions required under this subdivision.

Subd. 8. **Certification for lead–safe housing.** The commissioner shall propose to the legislature a program to certify residences as lead safe by February 15, 1996.

Subd. 9. **Landlord tenant study.** The commissioner of health shall conduct or contract for a study of the legal responsibilities of tenants and landlords in the prevention of lead hazards, and shall report the findings to the legislature, along with recommendations as to any changes needed to clarify or modify current law by January 15, 1996. In conducting the study, the commissioner shall convene any public meetings necessary to hear the testimony

and recommendations of interested parties, and shall invite and consider written public comments.

History: *1995 c 213 art 1 s 5*

144.9504 SECONDARY PREVENTION.

Subdivision 1. **Jurisdiction.** (a) A board of health serving cities of the first class must conduct lead inspections for purposes of secondary prevention, according to the provisions of this section. A board of health not serving cities of the first class must conduct lead inspections for the purposes of secondary prevention, unless they certify in writing to the commissioner by January 1, 1996, that they desire to relinquish these duties back to the commissioner. At the discretion of the commissioner, a board of health may, upon written request to the commissioner, resume these duties.

(b) Inspections must be conducted by a board of health serving a city of the first class. The commissioner must conduct lead inspections in any area not including cities of the first class where a board of health has relinquished to the commissioner the responsibility for lead inspections. The commissioner shall coordinate with the board of health to ensure that the requirements of this section are met.

(c) The commissioner may assist boards of health by providing technical expertise, equipment, and personnel to boards of health. The commissioner may provide laboratory or field lead–testing equipment to a board of health or may reimburse a board of health for direct costs associated with lead inspections.

(d) The commissioner shall enforce the rules under section 144.9508 in cases of voluntary lead hazard reduction.

Subd. 2. **Lead inspection.** (a) An inspecting agency shall conduct a lead inspection of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 70 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 20 micrograms of lead per deciliter of whole blood; or

(4) within ten working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification.

(b) Within the limits of available state and federal appropriations, an inspecting agency may also conduct a lead inspection for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an inspecting agency shall inspect the individual unit in which the conditions of this section are met and shall also inspect all common areas. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the inspecting agency shall also inspect the other sites. The inspecting agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead inspection for each additional site.

(d) The inspecting agency shall identify the known addresses for the previous 12 months of the child or pregnant female with elevated blood lead levels; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them a copy of the lead inspection guide. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The inspecting agency shall conduct the lead inspection according to rules adopted by the commissioner under section 144.9508. An inspecting agency shall have lead inspections performed by lead inspectors licensed by the commissioner according to rules adopted

under section 144.9508. If a property owner refuses to allow an inspection, the inspecting agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead inspection set forth in this subdivision no longer applies. An inspector or inspecting agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, dust, and drinking water must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces.

(f) A lead inspector shall notify the commissioner and the board of health of all violations of lead standards under section 144.9508, that are identified in a lead inspection conducted under this section.

(g) Each inspecting agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the inspecting agency. Inspecting agencies must consider appeals that propose lower cost methods that make the residence lead safe.

(h) Sections 144.9501 to 144.9509 neither authorize nor prohibit an inspecting agency from charging a property owner for the cost of a lead inspection.

Subd. 3. **Lead education strategy.** At the time of a lead inspection or following a lead order, the inspecting agency shall ensure that a family will receive a visit at their residence by a swab team worker or public health professional, such as a nurse, sanitarian, public health educator, or other public health professional. The swab team worker or public health professional shall inform the property owner, landlord, and the tenant of the health–related aspects of lead exposure; nutrition; safety measures to minimize exposure; methods to be followed before, during, and after the lead hazard reduction process; and community, legal, and housing resources. If a family moves to a temporary residence during the lead hazard reduction process, lead education services should be provided at the temporary residence whenever feasible.

Subd. 4. **Lead inspection guides.** (a) The commissioner of health shall develop or purchase lead inspection guides that enable parents and other caregivers to assess the possible lead sources present and that suggest lead hazard reduction actions. The guide must provide information on lead hazard reduction and disposal methods, sources of equipment, and telephone numbers for additional information to enable the persons to either select a lead contractor or perform the lead hazard reduction. The guides must explain:

(1) the requirements of this section and rules adopted under section 144.9508;

(2) information on the administrative appeal procedures required under this section;

(3) summary information on lead–safe directives;

(4) be understandable at an eighth grade reading level; and

(5) be translated for use by non–English–speaking persons.

(b) An inspecting agency shall provide the lead inspection guides at no cost to:

(1) parents and other caregivers of children who are identified as having blood lead levels of at least ten micrograms of lead per deciliter of whole blood;

(2) all property owners who are issued housing code or lead orders requiring lead hazard reduction of lead sources and all occupants of those properties; and

(3) occupants of residences adjacent to the inspected property.

(c) An inspecting agency shall provide the lead inspection guides on request to owners or occupants of residential property, builders, contractors, inspectors, and the public within the jurisdiction of the inspecting agency.

Subd. 5. **Lead orders.** An inspecting agency, after conducting a lead inspection, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead inspections and lead orders are conducted at times when weather or soil conditions do not permit the lead inspection or lead hazard reduction, external surfaces and soil lead shall be inspected, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow. If the paint standard under section 144.9508 is violated, but the paint is intact, the inspecting agency shall not order the paint to be removed unless the intact paint is a known source of actual lead

exposure to a specific person. Before the inspecting agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods. Whenever windows and doors or other components covered with deteriorated lead–based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or be planed down to remove deteriorated lead–based paint or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead–containing interior surfaces. The inspecting agency is not required to pay for lead hazard reduction. Lead orders must be issued within 30 days of receiving the blood lead level analysis. The inspecting agency shall enforce the lead orders issued to a property owner under this section. A copy of the lead order must be forwarded to the commissioner.

Subd. 6. **Swab team services.** After a lead inspection or after issuing lead orders, the inspecting agency, within the limits of appropriations and availability, shall offer the property owner the services of a swab team free of charge and, if accepted, shall send a swab team within ten working days to the residence to perform swab team services as defined in section 144.9501. If the inspecting agency provides swab team services after a lead inspection, but before the issuance of a lead order, swab team services do not need to be repeated after the issuance of the lead order if the swab team services fulfilled the lead order. Swab team services are not considered completed until the clearance inspection required under this section shows that the property is lead safe.

Subd. 7. **Relocation of residents.** (a) An inspecting agency shall ensure that residents are relocated from rooms or dwellings during a lead hazard reduction process that generates leaded dust, such as removal or disruption of lead–based paint or plaster that contains lead. Residents shall not remain in rooms or dwellings where the lead hazard reduction process is occurring. An inspecting agency is not required to pay for relocation unless state or federal funding is available for this purpose. The inspecting agency shall make an effort to assist the resident in locating resources that will provide assistance with relocation costs. Residents shall be allowed to return to the residence or dwelling after completion of the lead hazard reduction process. An inspecting agency shall use grant funds under section 144.9507 if available, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low–income resident temporarily relocated during lead hazard reduction. For purposes of this section, "low–income resident" means any resident whose gross household income is at or below 185 percent of federal poverty level.

(b) A resident of rental property who is notified by an inspecting agency to vacate the premises during lead hazard reduction, notwithstanding any rental agreement or lease provisions:

(1) shall not be required to pay rent due the landlord for the period of time the tenant vacates the premises due to lead hazard reduction;

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises due to lead hazard reduction; and

(3) shall not, if the tenancy is terminated, be liable for any further rent or other charges due under the terms of the tenancy.

(c) A landlord of rental property whose tenants vacate the premises during lead hazard reduction shall:

(1) allow a tenant to return to the dwelling unit after lead hazard reduction and clearance inspection, required under this section, is completed, unless the tenant has elected to terminate the tenancy as provided for in paragraph (b); and

(2) return any security deposit due under section 504.20 within five days of the date the tenant vacates the unit, to any tenant who terminates tenancy as provided for in paragraph (b).

Subd. 8. **Property owner responsibility.** Property owners shall comply with lead orders issued under this section within 60 days or be subject to enforcement actions as provided under section 144.9509. For orders or portions of orders concerning external lead hazards, property owners shall comply within 60 days, or as soon thereafter as weather permits. If the property owner does not use a lead contractor for compliance with the lead orders, the prop-

erty owner shall submit a plan for approval by the inspecting agency within 30 days after receiving the orders. The plan must include the details required in section 144.9505 as to how the property owner intends to comply with the lead orders and notice as to when lead hazard reduction activities will begin.

Subd. 9. **Clearance inspection.** After completion of swab team services and compliance with the lead orders by the property owner, including any repairs ordered by a local housing or building inspector, the inspecting agency shall conduct a clearance inspection by visually inspecting the residence for deteriorated paint and bare soil and retest the dust lead concentration in the residence to assure that violations of the lead standards under section 144.9508 no longer exist. The inspecting agency is not required to test a dwelling unit after lead hazard reduction that was not ordered by the inspecting agency.

Subd. 10. **Case closure.** A lead inspection is completed and the responsibility of the inspecting agency ends when all of the following conditions are met:

(1) lead orders are written on all known sources of violations of lead standards under section 144.9508;

(2) compliance with all lead orders has been completed; and

(3) clearance inspections demonstrate that no deteriorated lead paint, bare soil, or lead dust levels exist that exceed the standards adopted under section 144.9508.

Subd. 11. **Local ordinances.** No unit of local government shall have an ordinance, regulation, or practice which requires property owners to comply with any lead hazard reduction order in a period of time shorter than the period established for compliance with lead orders under this section.

History: *1995 c 213 art 1 s 6*

144.9505 LICENSING OF LEAD CONTRACTORS AND CERTIFICATION OF WORKERS.

Subdivision 1. **Licensing and certification.** (a) Lead contractors shall, before performing abatement or lead hazard reduction, obtain a license from the commissioner. Workers for lead contractors shall obtain certification from the commissioner. The commissioner shall specify training and testing requirements for licensure and certification as required in section 144.9508 and shall charge a fee for the cost of issuing a license or certificate and for training provided by the commissioner. Fees collected under this section shall be set in amounts to be determined by the commissioner to cover but not exceed the costs of adopting rules under section 144.9508, the costs of licensure, certification, and training, and the costs of enforcing licenses and certificates under this section. All fees received shall be paid into the state treasury and credited to the lead abatement licensing and certification account and are appropriated to the commissioner to cover costs incurred under this section and section 144.9508.

(b) Contractors shall not advertise or otherwise present themselves as lead contractors unless they have lead contractor licenses issued by the department of health.

Subd. 2. **Lead training.** Lead abatement and lead hazard reduction training must include a hands–on component and instruction on the health effects of lead exposure, the use of personal protective equipment, workplace hazards and safety problems, lead abatement and lead hazard reduction methods, lead–safe directives, decontamination procedures, cleanup and waste disposal procedures, lead monitoring and testing methods, swab team services, and legal rights and responsibilities.

Subd. 3. **Licensed building contractor; information.** The commissioner shall provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors licensed under section 326.84. The information must include the lead–safe directives and any other materials describing ways to protect the health and safety of both workers and residents.

Subd. 4. **Notice of lead abatement or lead hazard reduction work.** (a) At least five days before starting work at each lead abatement or lead hazard reduction worksite, the person performing the lead abatement or lead hazard reduction work shall give written notice and an approved work plan as required in this section to the commissioner and the appropriate board of health.

(b) This provision does not apply to swab team workers performing work under an order of an inspecting agency.

Subd. 5. **Abatement or lead hazard reduction plans.** (a) A lead contractor shall present a lead abatement or lead hazard reduction work plan to the property owner with each bid or estimate for lead abatement or lead hazard reduction work. The plan does not replace or supersede more stringent contractual agreements. A written lead abatement or lead hazard reduction plan must be prepared which describes the equipment and procedures to be used throughout the lead abatement or lead hazard reduction work project. At a minimum, the plan must describe:

(1) the building area and building components to be worked on;

(2) the amount of lead–containing material to be removed, encapsulated, or enclosed;

(3) the schedule to be followed for each work stage;

(4) the workers' personal protection equipment and clothing;

(5) the dust suppression and debris containment methods;

(6) the lead abatement or lead hazard reduction methods to be used on each building component;

(7) cleaning methods;

(8) temporary, on–site waste storage, if any; and

(9) the methods for transporting waste material and its destination.

(b) A lead contractor shall itemize the costs for each item listed in paragraph (a) and for any other expenses associated with the lead abatement or lead hazard reduction work and shall present these costs to the property owner with any bid or estimate for lead abatement or lead hazard reduction work.

(c) A lead contractor shall keep a copy of the plan readily available at the worksite for the duration of the project and present it to the inspecting agency on demand.

(d) A lead contractor shall keep a copy of the plan on record for one year after completion of the project and shall present it to the inspecting agency on demand.

(e) This provision does not apply to swab team workers performing work under an order of an inspecting agency or providing services at no cost to a property owner with funding under a state or federal grant.

History: *1995 c 213 art 1 s 7*

144.9506 LICENSING OF LEAD INSPECTORS.

Subdivision 1. **License required.** (a) A lead inspector shall obtain a license before performing lead inspections and shall renew it annually. The commissioner shall charge a fee and require annual training, as specified in this section. A lead inspector shall have the inspector's license readily available at all times at an inspection site and make it available, on request, for inspection by the inspecting agency with jurisdiction over the site. A license shall not be transferred.

(b) Individuals shall not advertise or otherwise present themselves as lead inspectors unless licensed by the commissioner.

Subd. 2. **License application.** An application for a license or license renewal shall be on a form provided by the commissioner and shall include:

(1) a $50 nonrefundable fee, in a form approved by the commissioner; and

(2) evidence that the applicant has successfully completed a lead inspector training course approved under this section or from another state with which the commissioner has established reciprocity. The fee required in this section is waived for federal, state, or local government employees within Minnesota.

Subd. 3. **License renewal.** A license is valid for one year from the issuance date unless the commissioner revokes or suspends it, except that the initial license will be issued to expire one year after the completion date on the approved training course diploma. An applicant shall successfully complete either an approved annual refresher lead inspection training course or a repeat of the approved initial lead inspection training course in order to apply for license renewal.

Subd. 4. **License replacement.** A licensed lead inspector may obtain a replacement license by reapplying for a license. A replacement expires on the same date as the original license. A nonrefundable $25 fee is required with each replacement application.

Subd. 5. **Approval of lead inspection course.** A lead inspection course sponsored by the United States Environmental Protection Agency is an approved course for the purpose of this section, providing it covers the criteria listed in section 144.9505. The commissioner shall evaluate for approval by permit lead inspector courses other than those approved by the United States Environmental Protection Agency.

History: *1995 c 213 art 1 s 8*

144.9507 LEAD–RELATED FUNDING.

Subdivision 1. **Lead education strategy contracts.** The commissioner shall, within available federal or state appropriations, contract with:

(1) boards of health to provide funds for lead education as provided for in sections 144.9503 and 144.9504; and

(2) swab team workers and community–based advocacy groups to provide funds for lead education for primary prevention of toxic lead exposure in areas at high risk for toxic lead exposure.

Subd. 2. **Lead inspection contracts.** The commissioner shall, within available federal or state appropriations, contract with boards of health to conduct lead inspections to determine sources of lead contamination and to issue and enforce lead orders according to section 144.9504.

Subd. 3. **Temporary lead–safe housing contracts.** The commissioner shall, within the limits of available appropriations, contract with boards of health for temporary housing, to be used in meeting relocation requirements in section 144.9504, and award grants to boards of health for the purposes of paying housing and relocation costs under section 144.9504.

Subd. 4. **Lead cleanup equipment and material grants.** The commissioner shall, within the limits of available state or federal appropriations, provide funds for lead cleanup equipment and materials under a grant program to nonprofit community–based organizations in areas at high risk for toxic lead exposure, as provided for in section 144.9503.

Subd. 5. **Federal lead–related funds.** To the extent practicable under federal guidelines, the commissioner of health shall coordinate with the commissioner of housing finance so that at least 50 percent of federal lead funds are allocated for swab team services.

To the extent practicable under federal guidelines, the commissioner of health may also use federal funding to contract with boards of health for purposes as specified in this section, but only to the extent that the federal funds do not replace existing funding for these lead services.

History: *1995 c 213 art 1 s 9*

144.9508 RULES.

Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule, visual inspection and sampling and analysis methods for:

(1) lead inspections under section 144.9504;

(2) environmental surveys of lead in paint, soil, dust, and drinking water to determine census tracts that are areas at high risk for toxic lead exposure;

(3) soil sampling for soil used as replacement soil; and

(4) drinking water sampling, which shall be done in accordance with lab certification requirements and analytical techniques specified by Code of Federal Regulations, title 40, section 141.89.

Subd. 2. **Lead standards and methods.** (a) The commissioner shall adopt rules establishing lead hazard reduction standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall differentiate between intact paint and deteriorated paint. The commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead–dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead–safe directives including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the pollution control agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for lead hazard reduction methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt lead hazard reduction standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt lead hazard reduction standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the pollution control agency shall adopt rules to ensure that removal of exterior lead–based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All lead hazard reduction standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing lead hazard reduction standards or methods for lead in paint, dust, drinking water, or soil that require a different lead hazard reduction standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

Subd. 3. **Lead contractors and workers.** The commissioner shall adopt rules to license lead contractors and to certify workers of lead contractors who perform lead abatement or lead hazard reduction.

Subd. 4. **Lead training course.** The commissioner shall establish by rule a permit fee to be paid by a training course provider on application for a training course permit or renewal period for each lead–related training course required for certification or licensure.

Subd. 5. **Variances.** In adopting the rules required under this section, the commissioner shall provide variance procedures for any provision in rules adopted under this section, except for the numerical standards for the concentrations of lead in paint, dust, bare soil, and drinking water.

Subd. 6. **Program directives.** In order to achieve statewide consistency in the application of lead abatement standards, the commissioner shall issue program directives that interpret the application of rules under this section in ambiguous or unusual lead abatement situations. These program directives are guidelines to local boards of health. The commissioner

shall periodically review lead abatement orders and the program directives to determine if the rules under this section need to be amended to reflect new understanding of lead abatement practices and methods.

History: *1995 c 213 art 1 s 10*

144.9509 ENFORCEMENT.

Subdivision 1. **Enforcement.** When the commissioner exercises authority for enforcement, the provisions of sections 144.9501 to 144.9509 shall be enforced under the provisions of sections 144.989 to 144.993. The commissioner shall develop a model ordinance for boards of health to adopt to enforce section 144.9504. Boards of health shall enforce a lead order issued under section 144.9504 under a local ordinance or as a public health nuisance under chapter 145A.

Subd. 2. **Discrimination.** A person who discriminates against or otherwise sanctions an employee who complains to or cooperates with the inspecting agency in administering sections 144.9501 to 144.9509 is guilty of a petty misdemeanor.

Subd. 3. **Enforcement and status report.** The commissioner shall examine compliance with Minnesota's existing lead standards and rules and report to the legislature biennially, beginning February 15, 1997, including an evaluation of current lead program activities by the state and boards of health, the need for any additional enforcement procedures, recommendations on developing a method to enforce compliance with lead standards, and cost estimates for any proposed enforcement procedure. The report shall also include a geographic analysis of all blood lead assays showing incidence data and environmental analyses reported or collected by the commissioner.

History: *1995 c 213 art 1 s 11*

144.98 CERTIFICATION OF ENVIRONMENTAL LABORATORIES.

[For text of subds 1 and 2, see M.S.1994]

Subd. 3. **Fees.** (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

(1) base certification fee, $500; and

(2) test category certification fees:

Test Category	Certification Fee
Bacteriology	$200
Inorganic chemistry, fewer than four constituents	$100
Inorganic chemistry, four or more constituents	$300
Chemistry metals, fewer than four constituents	$200
Chemistry metals, four or more constituents	$500
Volatile organic compounds	$600
Other organic compounds	$600

(b) The total biennial certification fee is the base fee plus the applicable test category fees. The biennial certification fee for a contract laboratory is 1.5 times the total certification fee.

(c) Laboratories located outside of this state that require an on–site survey will be assessed an additional $1,200 fee.

(d) The commissioner of health may adjust fees under section 16A.1285 without rulemaking. Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

[For text of subds 4 and 5, see M.S.1994]

History: *1995 c 165 s 4; 1995 c 233 art 2 s 50*

144.99 ENFORCEMENT.

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13),

(14), and (15); 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.491; 144.495; 144.71 to 144.74; 144.9501 to 144.9509; 144.992; 326.37 to 326.45; 326.57 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

[For text of subds 2 and 3, see M.S.1994]

Subd. 4. **Administrative penalty orders.** The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The procedures in section 144.991 must be followed when issuing administrative penalty orders. Except in the case of repeated or serious violations, the penalty assessed in the order must be forgiven if the person who is subject to the order demonstrates in writing to the commissioner before the 31st day after receiving the order that the person has corrected the violation or has developed a corrective plan acceptable to the commissioner. The maximum amount of an administrative penalty order is $10,000 for each violator for all violations by that violator identified in an inspection or review of compliance.

[For text of subd 5, see M.S.1994]

Subd. 6. **Cease and desist.** The commissioner, or an employee of the department designated by the commissioner, may issue an order to cease an activity covered by subdivision 1 if continuation of the activity would result in an immediate risk to public health. An order issued under this paragraph is effective for a maximum of 72 hours. In conjunction with the issuance of the cease and desist order, the commissioner may post a sign to cease an activity until the cease and desist order is lifted and the sign is removed by the commissioner. The commissioner must seek an injunction or take other administrative action authorized by law to restrain activities for a period beyond 72 hours. The issuance of a cease and desist order does not preclude the commissioner from pursuing any other enforcement action available to the commissioner.

[For text of subd 7, see M.S.1994]

Subd. 8. **Denial or refusal to reissue permits, licenses, registrations, or certificates.** (a) The commissioner may deny or refuse to renew an application for a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1, if the applicant does not meet or fails to maintain the minimum qualifications for holding a permit, license, registration, or certificate or has any unresolved violations related to the activity for which the permit, license, registration, or certificate was issued.

(b) The commissioner may also deny or refuse to renew a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1 if the applicant has a persistent pattern of violations related to the permit, license, registration, or certificate, or if the applicant submitted false material information to the department in connection with the application.

(c) The commissioner may condition the grant or renewal of a permit, license, registration, or certificate on a demonstration by the applicant that actions needed to ensure compliance with the requirements of the statutes listed in subdivision 1 have been taken, or may place conditions on or issue a limited permit, license, registration, or certificate as a result of previous violations by the applicant.

[For text of subd 9, see M.S.1994]

Subd. 10. **Hearings related to denial, refusal to renew, suspension, or revocation of a permit, license, registration, or certificate.** If the commissioner proposes to deny, refuses to renew, suspends, or revokes a permit, license, registration, or certificate under subdivision 8 or 9, the commissioner must first notify, in writing, the person against whom the action is proposed to be taken and provide the person an opportunity to request a hearing under the contested case provisions of chapter 14. If the person does not request a hearing by notifying

the commissioner within 20 days after receipt of the notice of proposed action, the commissioner may proceed with the action without a hearing.

[For text of subd 11, see M.S.1994]

History: *1995 c 165 s 5–9; 1995 c 180 s 13; 1995 c 213 art 1 s 12*

144.991 ADMINISTRATIVE PENALTY ORDER PROCEDURE.

[For text of subds 1 to 4, see M.S.1994]

Subd. 5. **Expedited administrative hearing.** (a) Within 30 days after receiving an order or within 20 days after receiving notice that the commissioner has determined that a violation has not been corrected or appropriate steps have not been taken, the person subject to an order under this section may request an expedited hearing, using the procedures of Minnesota Rules, parts 1400.8510 to 1400.8612, to review the commissioner's action. The hearing request must specifically state the reasons for seeking review of the order. The person to whom the order is directed and the commissioner are the parties to the expedited hearing. The commissioner must notify the person to whom the order is directed of the time and place of the hearing at least 15 days before the hearing. The expedited hearing must be held within 30 days after a request for hearing has been filed with the commissioner unless the parties agree to a later date.

(b) All written arguments must be submitted within ten days following the close of the hearing. The hearing shall be conducted under Minnesota Rules, parts 1400.8510 to 1400.8612, as modified by this subdivision. The office of administrative hearings may, in consultation with the agency, adopt rules specifically applicable to cases under this section.

(c) The administrative law judge shall issue a report making recommendations about the commissioner's action to the commissioner within 30 days following the close of the record. The administrative law judge may not recommend a change in the amount of the proposed penalty unless the administrative law judge determines that, based on the factors in subdivision 1, the amount of the penalty is unreasonable.

(d) If the administrative law judge makes a finding that the hearing was requested solely for purposes of delay or that the hearing request was frivolous, the commissioner may add to the amount of the penalty the costs charged to the agency by the office of administrative hearings for the hearing.

(e) If a hearing has been held, the commissioner may not issue a final order until at least five days after receipt of the report of the administrative law judge. The person to whom an order is issued may, within those five days, comment to the commissioner on the recommendations and the commissioner will consider the comments. The final order may be appealed in the manner provided in sections 14.63 to 14.69.

(f) If a hearing has been held and a final order issued by the commissioner, the penalty shall be paid by 30 days after the date the final order is received unless review of the final order is requested under sections 14.63 to 14.69. If review is not requested or the order is reviewed and upheld, the amount due is the penalty, together with interest accruing from 31 days after the original order was received at the rate established in section 549.09.

[For text of subds 6 to 9, see M.S.1994]

History: *1995 c 165 s 10*