CHAPTER 144

DEPARTMENT OF HEALTH

144.057 BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) 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 157.17;

(2) individuals specified in section 245A.04, subdivision 3, paragraph (c), who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, and if the individual under study resides outside Minnesota, the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides;

(3) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245A.04, subdivision 3, paragraph (b), clause (2), when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

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 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. 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, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A. If an individual is disqualified, the department of human services shall notify the facility, the supplemental nursing services agency, 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, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A. 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, except for the provisions under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, paragraph (a).

Subd. 4. **Responsibilities of facilities and agencies.** Facilities and agencies 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 shall apply to these facilities and supplemental nursing services agencies. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

History: *1Sp2001 c 9 art 7 s 1; art 14 s 2*

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system based on the minimum data set, in accordance with section 144.072, with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

[For text of subd 2, see M.S.2000]

History: *1Sp2001 c 9 art 5 s 1*

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section

and according to section 256B.438. The reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) **Assessment reference date.** "Assessment reference date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.

(b) **Case mix index.** "Case mix index" means the weighting factors assigned to the RUG-III classifications.

(c) **Index maximization.** "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) **Minimum data set.** "Minimum data set" means the assessment instrument specified by the Health Care Financing Administration and designated by the Minnesota department of health.

(e) **Representative.** "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

(f) **Resource utilization groups or RUG.** "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

Subd. 3. **Resident reimbursement classifications.** (a) Resident reimbursement classifications shall be based on the minimum data set, version 2.0 assessment instrument, or its successor version mandated by the Health Care Financing Administration that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix classification issued by the Minnesota department of health. The facility manual for case mix classification shall be drafted by the Minnesota department of health and presented to the chairs of health and human services legislative committees by December 31, 2001.

(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):

(1) extensive services where a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation where a resident requires physical, occupational, or speech therapy;

(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; fever with vomiting, weight loss, or dehydration; tube feeding and aphasia; or is receiving radiation therapy;

(4) clinically complex status where a resident has burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, wounds, kidney failure, urinary tract infections, oxygen, or transfusions;

(5) impaired cognition where a resident has poor cognitive performance;

(6) behavior problems where a resident exhibits wandering, has hallucinations, or is physically or verbally abusive toward others, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning where a resident has no special clinical conditions.

(c) The commissioner of health shall establish resident classification according to a 34 group model based on the information on the minimum data set and within the

general domains listed in paragraph (b), clauses (1) to (7). Detailed descriptions of each resource utilization group shall be defined in the facility manual for case mix classification issued by the Minnesota department of health. The 34 groups are described as follows:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;

(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;

(7) RAA: requires rehabilitation services and ADL count is four to nine;

(8) SSC: requires special care and ADL count is 17 or 18;

(9) SSB: requires special care and ADL count is 15 or 16;

(10) SSA: requires special care and ADL count is seven to 14;

(11) CC2: clinically complex with depression and ADL count is 17 or 18;

(12) CC1: clinically complex with no depression and ADL count is 17 or 18;

(13) CB2: clinically complex with depression and ADL count is 12 to 16;

(14) CB1: clinically complex with no depression and ADL count is 12 to 16;

(15) CA2: clinically complex with depression and ADL count is four to 11;

(16) CA1: clinically complex with no depression and ADL count is four to 11;

(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;

(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;

(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;

(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;

(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;

(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;

(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;

(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;

(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18:

(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;

(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;

(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;

(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;

(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;

(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;

(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;

(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and

(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health case mix assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Health Care Financing Administration, in the Long Term Care Assessment Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Health Care Financing Administration, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment must be completed by day 14 following admission;

(2) an annual assessment must be completed within 366 days of the last comprehensive assessment;

(3) a significant change assessment must be completed within 14 days of the identification of a significant change; and

(4) the second quarterly assessment following either a new admission assessment, an annual assessment, or a significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an initial admission assessment for all residents who stay in the facility less than 14 days.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days in lieu of submitting an initial assessment. Facilities may make this election to be effective on the day of implementation of the revised case mix system.

(c) After implementation of the revised case mix system, nursing facilities must elect one of the options described in paragraphs (a) and (b) on the annual report to the commissioner of human services filed for each report year ending September 30. The election shall be effective on the following July 1.

(d) For residents who are admitted or readmitted and leave the facility on a frequent basis and for whom readmission is expected, the resident may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in paragraphs (a) and (b).

Subd. 6. **Penalties for late or nonsubmission.** A facility that fails to complete or submit an assessment for a RUG-III classification within seven days of the time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

Subd. 7. **Notice of resident reimbursement classification.** (a) A facility must elect between the options in clauses (1) and (2) to provide notice to a resident of the resident's case mix classification.

(1) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The commissioner must send notice of resident classification by first class mail. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notice from the commissioner of health.

(2) A facility may choose to provide a classification notice, as prescribed by the commissioner of health, to a resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the commissioner. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the commissioner. If a facility elects this option, the commissioner of health shall provide the facility with a list of residents and their case mix classifications as determined by the commissioner. A nursing facility may make this election to be effective on the day of implementation of the revised case mix system.

(3) After implementation of the revised case mix system, a nursing facility shall elect a notice of resident reimbursement classification procedure as described in clause (1) or (2) on the annual report to the commissioner of human services filed for each report year ending September 30. The election will be effective the following July 1.

(b) If a facility submits a correction to an assessment conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident or resident's representative is provided the resident's corrected notice of classification.

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100

fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs or assessment characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.438 through desk audits, on-site review of residents and their records, and interviews with staff and families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Resident Assessment Instrument Manual published by the Health Care Financing Administration.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) The commissioner may target facilities that demonstrate an atypical pattern of scoring minimum data set items, nonsubmission of assessments, late submission of assessments, or a previous history of audit changes of greater than 35 percent. The commissioner shall select at least 20 percent of the most current assessments submitted to the state for audit. Audits of assessments selected in the targeted facilities must focus on the factors leading to the audit. If the number of targeted assessments selected does not meet the threshold of 20 percent of the facility residents, then a stratified sample of the remainder of assessments shall be drawn to meet the quota. If

the total change exceeds 35 percent, the commissioner may conduct an expanded audit up to 100 percent of the remaining current assessments.

(2) Facilities that are not a part of the targeted group shall be placed in a general pool from which facilities will be selected on a random basis for audit. Every facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a targeted audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent of the most current assessments shall be selected for audit. If more than 20 percent of the RUGS-III classifications after the audit are changed, the audit shall be expanded to a second 15 percent sample. If the total change between the first and second samples exceed 35 percent, the commissioner may expand the audit to all of the remaining assessments.

(3) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(4) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud; or

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments.

(f) Within 15 working days of completing the audit process, the commissioner shall mail the written results of the audit to the facility, along with a written notice for each resident affected to be forwarded by the facility. The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the area nursing home ombudsman.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

History: *1Sp2001 c 9 art 5 s 2*

144.073 [Repealed, 2001 c 205 art 2 s 3]

144.0751 HEALTH STANDARDS.

(a) Safe drinking water or air quality standards established or revised by the commissioner of health must:

(1) be based on scientifically acceptable, peer-reviewed information; and

(2) include a reasonable margin of safety to adequately protect the health of infants, children, and adults by taking into consideration risks to each of the following health outcomes: reproductive development and function, respiratory function, immunologic suppression or hypersensitization, development of the brain and nervous system, endocrine (hormonal) function, cancer, general infant and child development, and any other important health outcomes identified by the commissioner.

(b) For purposes of this section, "peer-reviewed" means a scientifically based review conducted by individuals with substantial knowledge and experience in toxicology, health risk assessment, or other related fields as determined by the commissioner.

History: *1Sp2001 c 9 art 1 s 27*

144.08 [Repealed, 2001 c 205 art 2 s 3]

144.1202 UNITED STATES NUCLEAR REGULATORY COMMISSION AGREEMENT.

[For text of subds 1 to 3, see M.S.2000]

Subd. 4. **Agreement; conditions of implementation.** (a) An agreement entered into before August 2, 2003, must remain in effect until terminated under the Atomic Energy Act of 1954, United States Code, title 42, section 2021, paragraph (j). The governor may not enter into an initial agreement with the Nuclear Regulatory Commission after August 1, 2003. If an agreement is not entered into by August 1, 2003, any rules adopted under this section are repealed effective August 1, 2003.

(b) An agreement authorized under subdivision 1 must be approved by law before it may be implemented.

History: *1Sp2001 c 9 art 1 s 28*

144.1205 RADIOACTIVE MATERIAL; SOURCE AND SPECIAL NUCLEAR MATERIAL; FEES; INSPECTION.

Subdivision 1. **Application and license renewal fee.** When a license is required for radioactive material or source or special nuclear material by a rule adopted under section 144.1202, subdivision 2, an application fee according to subdivision 4 must be paid upon initial application for a license. The licensee must renew the license 60 days before the expiration date of the license by paying a license renewal fee equal to the application fee under subdivision 4. The expiration date of a license is the date set by the United States Nuclear Regulatory Commission before transfer of the licensing program under section 144.1202 and thereafter as specified by rule of the commissioner of health.

Subd. 2. **Annual fee.** A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is an amount equal to 80 percent of the application fee under subdivision 4, rounded to the nearest whole dollar.

Subd. 3. **Fee categories; incorporation of federal licensing categories.** (a) Fee categories under this section are equivalent to the licensing categories used by the United States Nuclear Regulatory Commission under Code of Federal Regulations, title 10, parts 30 to 36, 39, 40, 70, 71, and 150, except as provided in paragraph (b).

(b) The category of "Academic, small" is the type of license required for the use of radioactive materials in a teaching institution. Radioactive materials are limited to ten radionuclides not to exceed a total activity amount of one curie.

Subd. 4. **Application fee.** A licensee must pay an application fee as follows:

Radioactive material, source and special material	Application fee	U.S. Nuclear Regulatory Commission licensing category as reference
Type A broadscope	$20,000	Medical institution type A
Type B broadscope	$15,000	Research and development type B
Type C broadscope	$10,000	Academic type C
Medical use	$4,000	Medical Medical institution Medical private practice
Mobile nuclear medical laboratory	$4,000	Mobile medical laboratory

Medical special use sealed sources	$6,000	Teletherapy High dose rate remote afterloaders Stereotactic radiosurgery devices
In vitro testing	$2,300	In vitro testing laboratories
Measuring gauge, sealed sources	$2,000	Fixed gauges Portable gauges Analytical instruments Measuring systems - other
Gas chromatographs	$1,200	Gas chromatographs
Manufacturing and distribution	$14,700	Manufacturing and distribution - other
Distribution only	$8,800	Distribution of radioactive material for commercial use only
Other services	$1,500	Other services
Nuclear medicine pharmacy	$4,100	Nuclear pharmacy
Waste disposal	$9,400	Waste disposal service prepackage Waste disposal service processing/repackage
Waste storage only	$7,000	To receive and store radioactive material waste
Industrial radiography	$8,400	Industrial radiography fixed location Industrial radiography portable/temporary sites
Irradiator - self-shielded	$4,100	Irradiators self-shielded less than 10,000 curies
Irradiator - less than 10,000 Ci	$7,500	Irradiators less than 10,000 curies
Irradiator - more than 10,000 Ci	$11,500	Irradiators greater than 10,000 curies
Research and development, no distribution	$4,100	Research and development
Radioactive material possession only	$1,000	Byproduct possession only
Source material	$1,000	Source material shielding
Special nuclear material, less than 200 grams	$1,000	Special nuclear material plutonium-neutron sources less than 200 grams
Pacemaker manufacturing	$1,000	Pacemaker byproduct and/or special nuclear material - medical institution

General license distribution	$2,100	General license distribution
General license distribution, exempt	$1,500	General license distribution - certain exempt items
Academic, small	$1,000	Possession limit of ten radionuclides, not to exceed a total of one curie of activity
Veterinary	$2,000	Veterinary use
Well logging	$5,000	Well logging

Subd. 5. **Penalty for late payment.** An annual fee or a license renewal fee submitted to the commissioner after the due date specified by rule must be accompanied by an additional amount equal to 25 percent of the fee due.

Subd. 6. **Inspections.** The commissioner of health shall make periodic safety inspections of the radioactive material and source and special nuclear material of a licensee. The commissioner shall prescribe the frequency of safety inspections by rule.

Subd. 7. **Recovery of reinspection cost.** If the commissioner finds serious violations of public health standards during an inspection under subdivision 6, the licensee must pay all costs associated with subsequent reinspection of the source. The costs shall be the actual costs incurred by the commissioner and include, but are not limited to, labor, transportation, per diem, materials, legal fees, testing, and monitoring costs.

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay one-half of the application fee specified under subdivision 4. For a period of 181 days or more, the licensee must pay the entire application fee under subdivision 4.

Subd. 9. **Fees for license amendments.** A licensee must pay a fee to amend a license as follows:

(1) to amend a license requiring no license review including, but not limited to, facility name change or removal of a previously authorized user, no fee;

(2) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer, $200; and

(3) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes, $400.

History: *1Sp2001 c 9 art 1 s 29*

NOTE: This section, as added by Laws 2001, First Special Session chapter 9, article 1, section 29, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 1, section 29, the effective date.

144.122 LICENSE, PERMIT, AND SURVEY 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 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)	$7,055
Non-JCAHO hospitals	$4,680 plus $234 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$1,512
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$1,200
Psychiatric hospitals	$1,400
Rural health facilities	$1,100
Portable X-ray providers	$ 500
Home health agencies	$1,800
Outpatient therapy agencies	$ 800
End stage renal dialysis providers	$2,100
Independent therapists	$ 800
Comprehensive rehabilitation outpatient facilities	$1,200
Hospice providers	$1,700
Ambulatory surgical providers	$1,800
Hospitals	$4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

History: *1Sp2001 c 9 art 1 s 30*

144.1464 SUMMER HEALTH CARE INTERNS.

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and post-secondary summer health care intern program. The purpose of the program is to expose interested secondary and post-secondary pupils to various careers within the health care profession.

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals, clinics, nursing facilities, and home care providers 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;

(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, clinic, nursing facility, or home care provider, a pupil must:

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

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

(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 health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(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.

(d) Hospitals, clinics, nursing facilities, and home care providers 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, clinics, nursing facilities, and home care providers 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, clinic, nursing facility, or home care setting 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: *1Sp2001 c 9 art 1 s 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 10,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

[For text of subds 2 to 5, see M.S.2000]

History: *2001 c 171 s 2*

144.148 RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT PROGRAM.

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

(b) "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 10,000, according to United States Census Bureau Statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Subd. 2. **Program.** (a) The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals. Except as provided in paragraph (b), a grant shall not exceed $500,000 per hospital. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-quarter of the grant amount, which may include in-kind services, is available for the same purposes from nonstate resources.

(b) A grant shall not exceed $1,500,000 per eligible rural hospital that also satisfies the following criteria:

(1) is the only hospital in a county;

(2) has 25 or fewer licensed hospital beds with a net hospital operating margin not greater than an average of two percent over the three fiscal years prior to application;

(3) is located in a medically underserved community (MUC) or a health professional shortage area (HPSA);

(4) is located near a migrant worker employment site and regularly treats significant numbers of migrant workers and their families; and

(5) has not previously received a grant under this section prior to July 1, 1999.

[For text of subds 3 to 5, see M.S.2000]

Subd. 8. [Repealed, 1Sp2001 c 9 art 1 s 62]

History: *2001 c 171 s 3; 1Sp2001 c 9 art 1 s 32*

144.1481 RURAL HEALTH ADVISORY COMMITTEE.

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a 15-member rural health advisory committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathy licensed under chapter 147;

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

(9) a licensed health care professional from an occupation not otherwise represented on the committee;

(10) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

(11) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

[For text of subds 2 and 3, see M.S.2000]

History: *2001 c 161 s 20*

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;

(11) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

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

History: *2001 c 171 s 4*

144.1491 FAILURE TO COMPLETE OBLIGATED SERVICE.

Subdivision 1. **Penalties for breach of contract.** A program participant who fails to complete two years of obligated service shall repay the amount paid, as well as a financial penalty based upon the length of the service obligation not fulfilled. If the participant has served at least one year, the financial penalty is the number of unserved months multiplied by $1,000. If the participant has served less than one year, the financial penalty is the total number of obligated months multiplied by $1,000. The commissioner shall report to the appropriate health-related licensing board a participant who fails to complete the service obligation and fails to repay the amount paid or fails to pay any financial penalty owed under this subdivision.

[For text of subd 2, see M.S.2000]

History: *1Sp2001 c 9 art 13 s 1*

144.1499 PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS.

The commissioner of health, in consultation with an organization representing health care employers, long-term care employers, and educational institutions, may make grants to qualifying consortia as defined in section 116L.11, subdivision 4, for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. To qualify for a grant under this section, a consortium shall:

(1) develop a health and long-term care careers curriculum that provides career exploration and training in national skill standards for health care and long-term care and that is consistent with Minnesota graduation standards and other related requirements;

(2) offer programs for high school students that provide training in health and long-term care careers with credits that articulate into post-secondary programs; and

(3) provide technical support to the participating health care and long-term care employer to enable the use of the employer's facilities and programs for kindergarten to grade 12 health and long-term care careers education.

History: *1Sp2001 c 9 art 1 s 33*

144.1502 DENTISTS LOAN FORGIVENESS.

Subdivision 1. **Definition.** For purposes of this section, "qualifying educational loans" means government, commercial, and foundation loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a dentist.

Subd. 2. **Creation of account; loan forgiveness program.** A dentist education account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for dentists who agree to care for substantial numbers of state public program participants and other low- to moderate-income uninsured patients.

Subd. 3. **Eligibility.** To be eligible to participate in the loan forgiveness program, a dental student must submit an application to the commissioner of health while attending a program of study designed to prepare the individual to become a licensed dentist. For fiscal year 2002, applicants may have graduated from a dentistry program in calendar year 2001. A dental student who is accepted into the loan forgiveness program must sign a contract to agree to serve a minimum three-year service obligation during which at least 25 percent of the dentist's yearly patient encounters are delivered to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303. The service obligation shall begin no later than March 31 of the first year following completion of training. If fewer applications are submitted by dental students than there are participant slots available, the commissioner may consider applications submitted by dental program graduates who are licensed dentists. Dentists selected for loan forgiveness must comply with all terms and conditions of this section.

Subd. 4. **Loan forgiveness.** The commissioner of health may accept up to 14 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for practice serving public program patients, as indicated by experience or training. The commissioner shall give preference to applicants who have attended a Minnesota dentistry educational institution and to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to $10,000 per year of service, not to exceed $40,000 or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form

provided by the commissioner verifying that the participant is practicing as required under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 3.

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the service commitment under subdivision 3, the commissioner of health shall collect from the participant 100 percent of any payments made for qualified educational loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the dentist education account established under subdivision 2.

Subd. 6. **Suspension or waiver of obligation.** Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations in cases 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 and may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

History: *1Sp2001 c 9 art 1 s 34*

144.1761 [Repealed, 1Sp2001 c 9 art 15 s 33]

144.212 DEFINITIONS.

[For text of subds 1 to 2, see M.S.2000]

Subd. 2a. **Delayed registration.** "Delayed registration" means registration of a record of birth or death filed one or more years after the date of birth or death.

Subd. 3. **File.** "File" means to present a vital record or report for registration to the office of the state registrar and to have the vital record or report accepted for registration by the office of the state registrar.

[For text of subds 4 and 4a, see M.S.2000]

Subd. 5. **Registration.** "Registration" means the process by which vital records are completed, filed, and incorporated into the official records of the office of the state registrar.

[For text of subd 6, see M.S.2000]

Subd. 7. **System of vital statistics.** "System of vital statistics" includes the registration, collection, preservation, amendment, and certification of vital records, the collection of other reports required by sections 144.211 to 144.227, and related activities including the tabulation, analysis, publication, and dissemination of vital statistics.

Subd. 8. **Vital record.** "Vital record" means a record or report of birth, death, marriage, dissolution and annulment, and data related thereto. The birth record is not a medical record of the mother or the child.

Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from records and reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment, and related reports.

[For text of subd 10, see M.S.2000]

Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed with the state registrar which sets forth the following information:

(1) the current name and address of the affiant;

(2) any previous name by which the affiant was known;

(3) the original and adopted names, if known, of the adopted child whose original birth record is to be disclosed;

(4) the place and date of birth of the adopted child;

(5) the biological relationship of the affiant to the adopted child; and

(6) the affiant's consent to disclosure of information from the original birth record of the adopted child.

History: *1Sp2001 c 9 art 15 s 1-7*

144.213 OFFICE OF THE STATE REGISTRAR.

Subdivision 1. **Creation; state registrar.** The commissioner shall establish an office of the state registrar under the supervision of the state registrar. The commissioner shall furnish to local registrars the forms necessary for correct reporting of vital statistics, and shall instruct the local registrars in the collection and compilation of the data. The commissioner shall promulgate rules for the collection, filing, and registering of vital statistics information by state and local registrars, physicians, morticians, and others. Except as otherwise provided in sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to the collection, filing and registering of vital statistics shall remain in effect until repealed, modified or superseded by a rule promulgated by the commissioner.

[For text of subd 2, see M.S.2000]

Subd. 3. **Recordkeeping.** To preserve vital records the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in the office of the state registrar. The reproductions when certified by the state or local registrar shall be accepted as the original records.

History: *1Sp2001 c 9 art 15 s 32*

144.214 LOCAL REGISTRARS OF VITAL STATISTICS.

Subdivision 1. **Districts.** The counties of the state shall constitute the 87 registration districts of the state. A local registrar in each county shall be designated by the county board of commissioners. The local registrar in any city which maintains local registration of vital statistics shall be the agent of a board of health as authorized under section 145A.04. In addition, the state registrar may establish registration districts on United States government reservations and may appoint a local registrar for each registration district so established.

Subd. 2. **Failure of duty.** A local registrar who neglects or fails to discharge duties as provided by sections 144.211 to 144.227 may be relieved of the duties as local registrar by the state registrar after notice and hearing. The state registrar may appoint a successor to serve as local registrar. If a local registrar fails to file or transmit birth or death records, the state registrar shall obtain them by other means.

Subd. 3. **Duties.** The local registrar shall enforce the provisions of sections 144.211 to 144.227 and the rules promulgated thereunder within the registration district and shall promptly report violations of the laws or rules to the state registrar.

Subd. 4. **Designated morticians.** The state registrar may designate licensed morticians to receive records of death for filing, to issue burial permits, and to issue permits for the transportation of dead bodies or dead fetuses within a designated territory. The designated morticians shall perform duties as prescribed by rule of the commissioner.

History: *1Sp2001 c 9 art 15 s 8-10, 32*

144.215 BIRTH REGISTRATION.

Subdivision 1. **When and where to file.** A record of birth for each live birth which occurs in this state shall be filed with the state registrar within five days after the birth.

Subd. 2. **Rules governing birth registration.** The commissioner shall establish by rule an orderly mechanism for the registration of births including at least a designation for who must file the birth record, a procedure for registering births which occur in

moving conveyances, and a provision governing the names of the parent or parents to be entered on the birth record.

Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is determined by a court of competent jurisdiction, a declaration of parentage is executed under section 257.34, or a recognition of parentage is executed under section 257.75, the name of the father shall be entered on the birth record. If the order of the court declares the name of the child, it shall also be entered on the birth record. If the order of the court does not declare the name of the child, or there is no court order, then upon the request of both parents in writing, the surname of the child shall be defined by both parents.

Subd. 4. **Social security number registration.** (a) Parents of a child born within this state shall give the parents' social security numbers to the office of the state registrar at the time of filing the birth record, but the numbers shall not appear on the record.

(b) The social security numbers are classified as private data, as defined in section 13.02, subdivision 12, on individuals, but the office of the state registrar shall provide a social security number to the public authority responsible for child support services upon request by the public authority for use in the establishment of parentage and the enforcement of child support obligations.

Subd. 5. **Births occurring in an institution.** When a birth occurs in an institution or en route to an institution, the person in charge of the institution or that person's authorized designee shall obtain the personal data required under this section and shall prepare the record of birth. For purposes of this section, "institution" means a hospital or other facility that provides childbirth services.

Subd. 6. **Births occurring outside an institution.** When a birth occurs outside of an institution as defined in subdivision 5, the record of birth shall be filed by one of the following persons, in the indicated order of preference:

(1) the physician present at the time of the birth or immediately thereafter;

(2) in the absence of a physician, a person, other than the mother, present at the time of the birth or immediately thereafter;

(3) the father of the child;

(4) the mother of the child; or

(5) in the absence of the father and if the mother is unable, the person with primary responsibility for the premises where the child was born.

Subd. 7. **Evidence required to register a noninstitution birth within the first year of birth.** When a birth occurs in this state outside of an institution, as defined in subdivision 5, and the birth record is filed before the first birthday, evidence in support of the facts of birth shall be required. Evidence shall be presented by the individual responsible for filing the vital record under subdivision 6. Evidence shall consist of proof that the child was born alive, proof of pregnancy, and evidence of the mother's presence in this state on the date of the birth. If the evidence is not acceptable, the state registrar shall advise the applicant of the reason for not filing a birth record and shall further advise the applicant of the right of appeal to a court of competent jurisdiction.

History: *1Sp2001 c 9 art 15 s 11-15,32*

144.216 FOUNDLING REGISTRATION.

Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown parentage shall report within five days to the office of the state registrar such information as the commissioner may by rule require to identify the foundling.

Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall constitute the record of birth for the child. If the child is identified and a record of birth is found or obtained, the report registered under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

History: *1Sp2001 c 9 art 15 s 32*

144.217 DELAYED RECORDS OF BIRTH.

Subdivision 1. **Evidence required for filing.** Before a delayed record of birth is registered, the person presenting the delayed vital record for registration shall offer evidence of the facts contained in the vital record, as required by the rules of the commissioner. In the absence of the evidence required, the delayed vital record shall not be registered. No delayed record of birth shall be registered for a deceased person.

Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision 1, a person may petition the appropriate court for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered. The petition shall state:

(1) that the person for whom a delayed record of birth is sought was born in this state;

(2) that no record of birth can be found in the office of the state registrar;

(3) that diligent efforts by the petitioner have failed to obtain the evidence required in subdivision 1;

(4) that the state registrar has refused to register a delayed record of birth; and

(5) other information as may be required by the court.

Subd. 3. **Court order.** The court shall fix a time and place for a hearing on the petition and shall give the state registrar ten days' notice of the hearing. The state registrar may appear and testify in the proceeding. If the court is satisfied from the evidence received at the hearing of the truth of the statements in the petition, the court shall order the registration of the delayed vital record.

Subd. 4. [Repealed, 1Sp2001 c 9 art 15 s 16;33]

History: *1Sp2001 c 9 art 15 s 16*

144.218 REPLACEMENT BIRTH RECORDS.

Subdivision 1. **Adoption.** Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted person. The original record of birth is confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252. The information contained on the original birth record, except for the registration number, shall be provided on request to a parent who is named on the original birth record. Upon the receipt of a certified copy of a court order of annulment of adoption the state registrar shall restore the original vital record to its original place in the file.

Subd. 2. **Adoption of foreign persons.** In proceedings for the adoption of a person who was born in a foreign country, the court, upon evidence presented by the commissioner of human services from information secured at the port of entry or upon evidence from other reliable sources, may make findings of fact as to the date and place of birth and parentage. Upon receipt of certified copies of the court findings and the order or decree of adoption, a certificate of adoption, or a certified copy of a decree issued under section 259.60, the state registrar shall register a birth record in the new name of the adopted person. The certified copies of the court findings and the order or decree of adoption, certificate of adoption, or decree issued under section 259.60 are confidential, pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252. The birth record shall state the place of birth as specifically as possible and that the vital record is not evidence of United States citizenship.

Subd. 3. **Subsequent marriage of birth parents.** If, in cases in which a record of birth has been registered pursuant to section 144.215 and the birth parents of the child marry after the birth of the child, a replacement record of birth shall be registered upon presentation of a certified copy of the marriage certificate of the birth parents, and either a recognition of parentage or court adjudication of paternity. The original record of birth is confidential, pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

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

Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon the request of a court of another state, upon the filing of a declaration of parentage under section 257.34, or upon the filing of a recognition of parentage with a registrar, a replacement birth record must be registered consistent with the findings of the court, the declaration of parentage, or the recognition of parentage.

History: *1Sp2001 c 9 art 15 s 17*

144.219 [Repealed, 1Sp2001 c 9 art 15 s 33]

144.221 DEATH REGISTRATION.

Subdivision 1. **When and where to file.** A death record for each death which occurs in the state shall be filed with the state registrar or local registrar or with a mortician designated pursuant to section 144.214, subdivision 4, within five days after death and prior to final disposition.

Subd. 2. **Rules governing death registration.** The commissioner of health shall establish in rule an orderly mechanism for the registration of deaths including at least a designation for who must file the death record, a procedure for the registration of deaths in moving conveyances, and provision to include cause and certification of death and assurance of registration prior to final disposition.

Subd. 3. **When no body is found.** When circumstances suggest that a death has occurred although a dead body cannot be produced to confirm the fact of death, a death record shall not be registered until a court has adjudicated the fact of death.

History: *1Sp2001 c 9 art 15 s 18,19,32*

144.222 REPORTS OF FETAL OR INFANT DEATH.

[For text of subd 1, see M.S.2000]

Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant death syndrome shall be reported within five days to the state registrar.

History: *1Sp2001 c 9 art 15 s 20*

144.223 REPORT OF MARRIAGE.

Data relating to certificates of marriage registered shall be reported to the state registrar by the local registrar or designee of the county board in each of the 87 registration districts pursuant to the rules of the commissioner. The information in clause (1) necessary to compile the report shall be furnished by the applicant prior to the issuance of the marriage license. The report shall contain the following:

(1) personal information on bride and groom:

(i) name;

(ii) residence;

(iii) date and place of birth;

(iv) race;

(v) if previously married, how terminated; and

(vi) signature of applicant, date signed, and social security number; and

(2) information concerning the marriage:

(i) date of marriage;

(ii) place of marriage; and

(iii) civil or religious ceremony.

History: *1Sp2001 c 9 art 15 s 21*

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

Subdivision 1. **Public information; access to vital records.** Except as otherwise provided for in this section and section 144.2252, information contained in vital records shall be public information. Physical access to vital records shall be subject to the supervision and regulation of state and local registrars and their employees pursuant to rules promulgated by the commissioner in order to protect vital records from loss, mutilation or destruction and to prevent improper disclosure of vital records which are confidential or private data on individuals, as defined in section 13.02, subdivisions 3 and 12.

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older;

(3) under paragraph (b) or (e); or

(4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance, general assistance medical care, and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

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. Notwithstanding the designation of the private data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance, general assistance medical care, and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

Subd. 2b. **Commissioner of health; duties.** Notwithstanding the designation of certain of this data as confidential under subdivision 2 or private under subdivision 2a, the commissioner shall give the commissioner of human services access to birth record data and data contained in recognitions of parentage prepared according to section 257.75 necessary to enable the commissioner of human services to identify a child who is subject to threatened injury, as defined in section 626.556, subdivision 2, paragraph (l), by a person responsible for the child's care, as defined in section 626.556, subdivision 2, paragraph (b), clause (1). The commissioner shall be given access to all data included on official birth records.

Subd. 3. **Laws and rules for preparing vital records.** No person shall prepare or issue any vital record which purports to be an original, certified copy, or copy of a vital record except as authorized in sections 144.211 to 144.227 or the rules of the commissioner.

[For text of subds 4 to 6, see M.S.2000]

Subd. 7. **Certified birth or death record.** (a) The state or local registrar shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) the party responsible for filing the vital record;

(vii) the legal custodian or guardian or conservator of the subject;

(viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties. An authorized governmental agency includes the department of human services, the department of revenue, and the United States Immigration and Naturalization Service;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state or local registrar shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (vii), if, on behalf of the individual, a mortician designated to receive death records under section 144.214, subdivision 4, furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the

death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Subd. 8. **Standardized format for certified birth and death records.** No later than July 1, 2000, the commissioner shall develop a standardized format for certified birth records and death records issued by state and local registrars. The format shall incorporate security features in accordance with this section. The standardized format must be implemented on a statewide basis by July 1, 2001.

History: *2001 c 15 s 1; 2001 c 178 art 1 s 1; 1Sp2001 c 9 art 15 s 22-26,32*

144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.

(a) Whenever an adopted person requests the state registrar to disclose the information on the adopted person's original birth record, the state registrar shall act according to section 259.89.

(b) The state registrar shall provide a transcript of an adopted person's original birth record to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership. Information contained in the birth record may not be used to provide the adopted person information about the person's birth parents, except as provided in this section or section 259.83.

History: *1Sp2001 c 9 art 15 s 27*

144.226 FEES.

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

(a) The fee for the issuance of a certified vital record or a certification that the vital record cannot be found is $8. No fee shall be charged for a certified birth or death record that is reissued within one year of the original issue, if an amendment is made to the vital record and if the previously issued vital record is surrendered.

(b) The fee for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is $20.

(c) The fee for the filing of a delayed registration of birth or death is $20.

(d) The fee for the amendment of any vital record when requested more than 45 days after the filing of the vital record is $20. No fee shall be charged for an amendment requested within 45 days after the filing of the vital record.

(e) The fee for the verification of information from vital records is $8 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee shall be payable at the time of application.

(f) The fee for issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $8.

[For text of subd 2, see M.S.2000]

Subd. 3. **Birth record surcharge.** In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth record and for a certification that the vital record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance for deposit into the account for the children's trust fund for the prevention of child abuse established under section 119A.12. This surcharge shall not be charged under those circumstances in which no fee for a certified birth record is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of finance that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $2 for each certified and noncertified

birth or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the state treasurer to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth or death record is permitted under subdivision 1, paragraph (a).

History: *1Sp2001 c 9 art 1 s 35; art 15 s 28,29*

144.227 PENALTIES.

Subdivision 1. **False statements.** A person who intentionally makes a false statement in a certificate, vital record, or report required to be filed under sections 144.211 to 144.214 or 144.216 to 144.227, or in an application for an amendment thereof, or in an application for a certified vital record or who supplies false information intending that the information be used in the preparation of a report, vital record, certificate, or amendment thereof, is guilty of a misdemeanor.

Subd. 2. **Fraud.** A person who, without lawful authority and with the intent to deceive, willfully and knowingly makes, counterfeits, alters, obtains, possesses, uses, or sells a certificate, vital record, or report required to be filed under sections 144.211 to 144.227 or a certified certificate, vital record, or report, is guilty of a gross misdemeanor.

Subd. 3. **Birth registration.** A person who intentionally makes a false statement in a registration required under section 144.215 or in an application for an amendment to such a registration or who intentionally supplies false information intending that the information be used in the preparation of a registration under section 144.215 is guilty of a gross misdemeanor. This offense shall be prosecuted by the county attorney.

History: *1Sp2001 c 9 art 15 s 30*

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 appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. 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 regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 150A, 151, 153, or 153A, or Minnesota Rules, chapter 4666; (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.

[For text of subds 2 to 6, see M.S.2000]

History: *2001 c 211 s 2*

144.3831 FEES.

[For text of subd 1, see M.S.2000]

Subd. 2. **Collection and payment of fee.** The public water supply described in subdivision 1 shall:

(1) collect the fees assessed on its service connections;

(2) pay the department of health an amount equivalent to the fees based on the total number of service connections. The service connections for each public water supply described in subdivision 1 shall be verified every four years by the department of health; and

(3) pay one-fourth of the total yearly fee to the department of health each calendar quarter. In lieu of quarterly payments, a public water supply described in subdivision 1 with fewer than 50 service connections may make a single annual payment by June 30 each year. The fees payable to the department of health shall be deposited in the state treasury as nondedicated state government special revenue fund revenues.

[For text of subd 3, see M.S.2000]

History: *1Sp2001 c 5 art 7 s 3*

144.395 TOBACCO USE PREVENTION AND LOCAL PUBLIC HEALTH ENDOWMENT FUND.

[For text of subd 1, see M.S.2000]

Subd. 2. **Expenditures.** (a) Up to five percent of the fair market value of the fund on the preceding July 1, must be spent to reduce the human and economic consequences of tobacco use among the youth of this state through state and local tobacco prevention measures and efforts, and for other public health initiatives.

(b) Notwithstanding paragraph (a), on January 1, 2000, up to five percent of the fair market value of the fund is appropriated to the commissioner of health to distribute as grants under section 144.396, subdivisions 5 and 6, in accordance with allocations in paragraph (c), clauses (1) and (2). Up to $200,000 of this appropriation is available to the commissioner to conduct the statewide assessments described in section 144.396, subdivision 3.

(c) Beginning July 1, 2000, and on July 1 of each year thereafter, the money in paragraph (a) is appropriated as follows, except as provided in paragraphs (d) and (e):

(1) 67 percent to the commissioner of health to distribute as grants under section 144.396, subdivision 5, to fund statewide tobacco use prevention initiatives aimed at youth;

(2) 16.5 percent to the commissioner of health to distribute as grants under section 144.396, subdivision 6, to fund local public health initiatives aimed at tobacco use prevention in coordination with other local health-related efforts to achieve measurable improvements in health among youth; and

(3) 16.5 percent to the commissioner of health to distribute in accordance with section 144.396, subdivision 7.

(d) A maximum of $150,000 of each annual appropriation to the commissioner of health in paragraphs (b) and (c) may be used by the commissioner for administrative expenses associated with implementing this section.

(e) Beginning July 1, 2001, $1,250,000 of each annual appropriation to the commissioner under paragraph (c), clause (1), may be used to provide base level funding for the commissioner's tobacco prevention and control programs and activities. This appropriation must occur before any other appropriation under this subdivision.

[For text of subd 3, see M.S.2000]

History: *1Sp2001 c 9 art 1 s 36*

144.551 HOSPITAL CONSTRUCTION MORATORIUM.

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the

bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice county that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami county; or

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail county with 100 licensed acute care beds.

[For text of subds 2 to 4, see M.S.2000]

History: *1Sp2001 c 9 art 1 s 37*

144.6535 VARIANCE OR WAIVER.

Subdivision 1. **Request for variance or waiver.** A hospital may request that the commissioner grant a variance or waiver from the provisions of Minnesota Rules, chapter 4640 or 4645. A request for a variance or waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific rule or rules for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the variance or waiver.

Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the variance or waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in Minnesota Rules, chapter 4640 or 4645; and

(3) whether compliance with the rule or rules would impose an undue burden upon the applicant.

Subd. 3. **Notification of variance.** The commissioner must notify the applicant in writing of the decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the applicant.

Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or conditions attached to a variance or waiver have the same force and effect as the rules under Minnesota Rules, chapter 4640 or 4645, and are subject to the issuance of correction orders and penalty assessments in accordance with section 144.55.

(b) Fines for a violation of this section shall be in the same amount as that specified for the particular rule for which the variance or waiver was requested.

Subd. 5. **Renewal.** A request for renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in subdivision 1. A variance or waiver must be renewed by the commissioner if the applicant continues to satisfy the criteria in subdivision 2 and the alternative measures or conditions, if any, specified under subdivision 3 and demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

Subd. 6. **Denial, revocation, or refusal to renew.** The commissioner must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3 are not met. The applicant must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

Subd. 7. **Appeal procedure.** An applicant may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under chapter 14. The applicant must submit, within 15 days of the receipt of the commissioner's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the applicant contends the decision of the commissioner should

be reversed or modified. At the hearing, the applicant has the burden of proving that it satisfied the criteria specified in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3, except in a proceeding challenging the revocation of a variance or waiver.

History: *2001 c 29 s 1*

144.672 DUTIES OF COMMISSIONER; RULES.

Subdivision 1. **Rule authority.** The commissioner of health shall collect cancer incidence information, analyze the information, and conduct special studies designed to determine the potential public health significance of an increase in cancer incidence.

The commissioner shall adopt rules to administer the system, collect information, and distribute data. The rules must include, but not be limited to, the following:

(1) the type of data to be reported;

(2) standards for reporting specific types of data;

(3) payments allowed to hospitals, pathologists, and registry systems to defray their costs in providing information to the system;

(4) criteria relating to contracts made with outside entities to conduct studies using data collected by the system. The criteria may include requirements for a written protocol outlining the purpose and public benefit of the study, the description, methods, and projected results of the study, peer review by other scientists, the methods and facilities to protect the privacy of the data, and the qualifications of the researcher proposing to undertake the study; and

(5) specification of fees to be charged under section 13.03, subdivision 3, for all out-of-pocket expenses for data summaries or specific analyses of data requested by public and private agencies, organizations, and individuals, and which are not otherwise included in the commissioner's annual summary reports. Fees collected are appropriated to the commissioner to offset the cost of providing the data.

[For text of subd 2, see M.S.2000]

History: *2001 c 161 s 21*

144.9501 DEFINITIONS.

[For text of subds 1 and 2, see M.S.2000]

Subd. 3. **Abatement.** "Abatement" means any set of measures intended to eliminate known or presumed lead hazards. Abatement includes:

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

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

Subd. 4. **Areas at high risk for toxic lead exposure.** "Areas at high risk for toxic lead exposure" means a census tract in a city of the first class or a county or area within a county outside a city of the first class that has been determined to be at high risk for toxic lead exposure under section 144.9503.

[For text of subds 4a to 6b, see M.S.2000]

Subd. 6c. **Capillary blood sample.** "Capillary blood sample" means a quantity of blood drawn from a capillary. The sample generally is collected by fingerstick.

Subd. 6d. **Certified lead firm.** "Certified lead firm" means a person that employs individuals to perform regulated lead work and that is certified by the commissioner under section 144.9505.

[For text of subd 7, see M.S.2000]

Subd. 7a. **Contracting entity.** "Contracting entity" means a public or private body, board, individual, corporation, partnership, proprietorship, joint venture, fund, authority, or similar entity that contracts with a person to do regulated lead work.

[For text of subds 8 and 9, see M.S.2000]

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 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; or covering bare soil that exceeds the standards under section 144.9508 with an impermeable material, such as asphalt or concrete.

[For text of subd 13, see M.S.2000]

Subd. 13a. **Interim controls.** "Interim controls" means a set of measures intended to temporarily reduce human exposure or likely exposure to known or presumed lead hazards, including specialized cleaning, repairs, maintenance, painting, temporary encapsulation, or enclosure.

[For text of subd 15, see M.S.2000]

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim controls undertaken 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.

Subd. 17a. **Lead hazard screen.** "Lead hazard screen" means a limited risk assessment activity that involves the visual identification of dust, paint, or bare soil and sampling and analysis of dust.

Subd. 17b. **Lead interim control worker.** "Lead interim control worker" means an individual who is trained as specified by the commissioner to conduct interim control activities.

Subd. 18. **Lead inspection.** "Lead inspection" means a surface by surface investigation to determine the presence of lead content of paint and a visual identification of the existence and location of bare soil.

Subd. 19. **Lead inspector.** "Lead inspector" means a person who is licensed by the commissioner to perform a lead inspection under section 144.9505.

Subd. 19a. **Lead project design.** "Lead project design" means site-specific written project specifications for a regulated lead work project. Lead project design includes written technical project specifications incorporated into bidding documents.

[For text of subd 20, see M.S.2000]

Subd. 20a. **Lead project designer.** "Lead project designer" means an individual who is responsible for planning the site-specific performance of regulated lead work and who has been licensed by the commissioner under section 144.9505.

Subd. 20b. **Lead risk assessment.** "Lead risk assessment" means an investigation to determine the existence, nature, severity, and location of lead hazards.

Subd. 20c. **Lead risk assessor.** "Lead risk assessor" means an individual who performs lead risk assessments or lead inspections and who has been licensed by the commissioner under section 144.9505.

Subd. 21. **Lead-safe.** "Lead-safe" means a condition in which:

(1) lead is not present;

(2) 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

(3) if the lead concentrations in the paint or soil do exceed the standards, the paint is intact and the soil is not bare soil.

Subd. 22. **Lead-safe practices.** "Lead-safe practices" means methods for construction, renovation, remodeling, or maintenance activities that are not regulated lead work 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. 22a. **Lead supervisor.** "Lead supervisor" means an individual who is responsible for the on-site performance of abatement or interim controls and who has been licensed by the commissioner under section 144.9505.

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for nonabatement or nonorder lead hazard reduction sites, lead dust sampling in other settings, or visual assessment for deteriorated paint, and who is registered with the commissioner under section 144.9505.

Subd. 23. **Lead worker.** "Lead worker" means an individual who performs abatement or interim control work and who has been licensed by the commissioner under section 144.9505.

[For text of subds 24 to 26, see M.S.2000]

Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services; or

(9) swab team services.

(b) Regulated lead work does not include:

(1) activities such as remodeling, renovation, installation, rehabilitation, or landscaping activities, the primary intent of which is to remodel, repair, or restore a structure or dwelling, rather than to permanently eliminate lead hazards, even though these activities may incidentally result in a reduction in lead hazards; or

(2) interim control activities that are not performed as a result of a lead order and that do not disturb painted surfaces that total more than:

(i) 20 square feet (two square meters) on exterior surfaces;

(ii) two square feet (0.2 square meters) in an interior room; or

(iii) ten percent of the total surface area on an interior or exterior type of component with a small surface area.

[For text of subds 27 and 28, see M.S.2000]

Subd. 28a. **Standard.** "Standard" means a quantitative assessment of lead in any environmental media or consumer product.

Subd. 29. **Swab team services.** "Swab team services" means activities that provide protection from lead hazards primarily through the use of interim controls, 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 repainting 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.

[For text of subds 30 and 31, see M.S.2000]

Subd. 32. [Repealed, 2001 c 205 art 1 s 43]

History: *2001 c 205 art 1 s 1-25*

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

[For text of subds 1 to 5, see M.S.2000]

Subd. 6. [Repealed, 2001 c 205 art 1 s 43]

[For text of subd 7, see M.S.2000]

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, or dust must be a laboratory recognized by the United States Environmental Protection Agency under the Toxic Substances Control Act, United States Code, title 15, section 2685, paragraph (b). Analysis of samples of drinking water must be performed by a laboratory certified by the commissioner to analyze lead in water.

[For text of subd 9, see M.S.2000]

History: *2001 c 205 art 1 s 26*

144.9503 PRIMARY PREVENTION.

Subdivision 1. **Primary prevention program.** The commissioner shall develop and maintain a primary prevention program to reduce lead exposure in young children and pregnant women. A board of health serving a city of the first class shall determine areas at high risk for toxic lead exposure before doing primary prevention lead hazard reduction activities. The program shall provide primary prevention lead education materials, promote primary prevention swab team services in cooperation with the commissioner of economic security or housing finance, provide lead cleanup equipment and material grants as funding allows, monitor regulated lead work, and develop and maintain lead-safe practices in cooperation with the commissioner of administration.

Subd. 2. **Priorities for primary prevention.** (a) The commissioner of health and boards of health serving cities of the first class shall determine areas at high risk for toxic lead exposure.

(b) A board of health serving a city of the first class shall rank order census tracts by awarding points as specified in this paragraph. 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.

(1) One point may be awarded to a census tract 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, provided the commissioner has determined that the data used to award the points are comprehensive and representative.

(2) One point may 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.

(3) One point may be awarded for every 100 parts per million of lead in soil, based on the median soil lead values of foundation soil samples, calculated on 100 parts per million intervals, or fraction thereof. A board of health shall use data from its own soil survey conducted according to rules adopted under section 144.9508, except that a board of health serving Minneapolis or St. Paul that has not conducted its own soil survey 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 board of health shall make a reasoned determination of the median foundation soil lead value for that census tract.

(4) A board of health may award one point to each census tract for each of the following factors based on cutoff criteria to be determined by the board of health:

(i) percent of minority population;

(ii) number of children less than six years of age;

(iii) percent of housing built before 1950; and

(iv) percent of population living in poverty.

(c) The commissioner may determine areas at high risk for toxic lead exposure at the county level or within a county outside a city of the first class using one or more of the following criteria:

(1) blood lead levels greater than ten micrograms per deciliter of whole blood in children under six years of age;

(2) percent of dilapidated or deteriorated housing;

(3) soil lead levels in excess of 100 parts per million;

(4) percent of minority population;

(5) percent of housing built before 1950;

(6) percent of children living in poverty; or

(7) other factors appropriate in preventing lead exposure, as determined by a federal agency including the United States Centers for Disease Control and Prevention, the United States Environmental Protection Agency, or the United States Department of Housing and Urban Development.

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

(1) 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) providing lead education materials to the general public;

(3) providing lead education materials to property owners, landlords, and tenants by swab team workers and public health professionals, such as nurses, sanitarians, health educators, nonprofit organizations working on lead issues, and other public health professionals in areas at high risk for toxic lead exposure; and

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

Subd. 4. **Swab team services.** Primary prevention may include the use of swab team services. The swab team services may be provided based on lead hazard screens whenever possible and must at least include lead hazard reduction for deteriorated interior lead-based paint, bare soil, and dust.

Subd. 6. [Repealed, 2001 c 205 art 1 s 27,43]

Subd. 7. **Lead-safe practices information.** The commissioner shall develop and maintain in cooperation with the commissioner of administration provisions and procedures to define lead-safe practices information for residential remodeling, renovation, installation, and rehabilitation activities that are not lead hazard reduction, but may disrupt lead-based paint surfaces and guidance documents for the regulated industry.

History: *2001 c 205 art 1 s 27*

144.9504 SECONDARY PREVENTION.

Subdivision 1. **Jurisdiction.** (a) A board of health serving cities of the first class must conduct lead risk assessments 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 risk assessments for the purposes of secondary prevention, unless they certified in writing to the commissioner by January 1, 1996, that they desired 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) Lead risk assessments must be conducted by a board of health serving a city of the first class. The commissioner must conduct lead risk assessments in any area not including cities of the first class where a board of health has relinquished to the commissioner the responsibility for lead risk assessments. 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 risk assessments.

Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (5) 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 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;

(4) within ten working days of a child 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; or

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

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

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. 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 assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 20 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; 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 primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing 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, and dust 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. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing 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 assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

[For text of subd 3, see M.S.2000]

Subd. 4. [Repealed, 2001 c 205 art 1 s 43]

Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment, 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 risk assessments and lead orders are conducted at times when weather or soil conditions do not permit the lead risk assessment or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow.

(b) If the paint standard under section 144.9508 is violated, but the paint is intact, the assessing 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 assessing 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.

(c) 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 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. However, a property owner who has been ordered to perform lead hazard reduction may choose any method to address deteriorated lead-based paint on windows, doors, or other components, provided that the method is approved in rules adopted under section 144.9508 and that it is appropriate to the specific property.

(d) 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.

(e) The assessing agency is not required to pay for lead hazard reduction. The assessing agency shall enforce the lead orders issued to a property owner under this section.

[For text of subd 6, see M.S.2000]

Subd. 7. **Relocation of residents.** (a) Within the limits of appropriations, the assessing 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 assessing agency is not required to pay for relocation unless state or federal funding is available for this purpose. The assessing 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 room or dwelling after completion of the lead hazard reduction process. An assessing 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 assessing 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 504B.178 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 notification responsibility.** If the property owner does not hire a person licensed by the commissioner under section 144.9505 for compliance with the lead orders, the property owner shall submit a notice as to when regulated lead work will begin, according to section 144.9505, subdivision 4, to the assessing agency within 30 days after receiving the orders.

[For text of subds 9 and 10, see M.S.2000]

Subd. 11. [Repealed, 2001 c 205 art 1 s 43]

History: *2001 c 205 art 1 s 28-32*

144.9505 LICENSING OF LEAD FIRMS AND PROFESSIONALS.

Subdivision 1. **Licensing and certification; generally.** (a) 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) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, or lead firms unless they have licenses or certificates issued by or are registered with the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) An individual who is the owner of property on which regulated lead work is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.

(e) A person that employs individuals to perform regulated lead work outside of the person's property must obtain certification as a certified lead firm. An individual who performs regulated lead work must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other individual who performs regulated lead work, the individual is employed by a person that does not perform regulated lead work outside of the person's property, or the individual is employed by an assessing agency.

Subd. 1a. **Lead worker license.** Before an individual performs regulated lead work as a worker, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead hazard control. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1b. **Lead supervisor license.** Before an individual performs regulated lead work as a supervisor, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and

successful completion of a training course in lead hazard control. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $50 fee for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1c. **Lead inspector license.** Before an individual performs lead inspection services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead inspection. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1d. **Lead risk assessor license.** Before an individual performs lead risk assessor services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead risk assessment. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1e. **Lead project designer license.** Before an individual performs lead project designer services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead project design. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1f. **Lead sampling technician.** An individual performing lead sampling technician services shall first register with the commissioner. The commissioner shall not register an individual unless the individual shows evidence of successfully completing a training course in lead sampling. The commissioner shall specify the course of training and testing requirements. Proof of registration must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1g. **Certified lead firm.** A person within the state intending to directly perform or cause to be performed through subcontracting or similar delegation any regulated lead work shall first obtain certification from the commissioner. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. The certification fee is $100, is nonrefundable, and must be submitted with each application. The certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 2. [Repealed, 2001 c 205 art 1 s 33,43]

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 practices and any other materials describing ways to protect the health and safety of both employees and residents.

Subd. 4. **Notice of regulated lead work.** (a) At least five working days before starting work at each regulated lead worksite, the person performing the regulated lead work shall give written notice to the commissioner and the appropriate board of health.

(b) This provision does not apply to lead hazard screen, lead inspection, lead risk assessment, lead sampling technician, or lead project design activities.

Subd. 5. [Repealed, 2001 c 205 art 1 s 33,43]

Subd. 6. **Duties of contracting entity.** A contracting entity intending to have regulated lead work performed for its benefit shall include in the specifications and contracts for the work a requirement that the work be performed by contractors and subcontractors licensed by the commissioner under sections 144.9501 to 144.9509 and according to rules adopted by the commissioner related to regulated lead work. No contracting entity shall allow regulated lead work to be performed for its benefit unless the contracting entity has seen that the person has a valid license or certificate. A contracting entity's failure to comply with this subdivision does not relieve a person from any responsibility under sections 144.9501 to 144.9509.

History: *2001 c 205 art 1 s 33*

144.9506 [Repealed, 2001 c 205 art 1 s 43]

144.9507 LEAD-RELATED FUNDING.

[For text of subds 1 to 3, see M.S.2000]

Subd. 5. **Federal lead-related funds.** To the extent practicable under federal guidelines, the commissioner of health may use federal funding to contract with boards of health for purposes specified in this section, but only to the extent that the federal funds do not replace existing funding for these lead services.

History: *2001 c 205 art 1 s 34*

144.9508 RULES.

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

(1) lead inspections, lead hazard screens, lead risk assessments, and clearance inspections;

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

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

(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; and

(5) sampling to determine whether at least 25 percent of the soil samples collected from a census tract within a standard metropolitan statistical area contain lead in concentrations that exceed 100 parts per million.

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work 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 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 reduc-

tion methods adopted under this section may be used for lead-safe practices 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 regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work 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 regulated lead work 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 regulated lead work 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 regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work 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.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9509.

[For text of subd 2a, see M.S.2000]

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, and lead risk assessors. The commissioner shall also adopt rules requiring certification of firms that perform regulated lead work and rules requiring registration of lead sampling technicians. The commissioner shall require periodic renewal of licenses, certificates, and registrations and shall establish the renewal periods.

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in

rules for the content and presentation of training courses for lead interim control workers. Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.

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. A variance shall be considered only according to the procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

Subd. 6. [Repealed, 2001 c 205 art 1 s 43]

History: *2001 c 205 art 1 s 35-39*

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. 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.

[For text of subd 2, see M.S.2000]

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 summary of lead surveillance data collected by the commissioner.

History: *2001 c 205 art 1 s 40,41*

144.98 CERTIFICATION OF ENVIRONMENTAL LABORATORIES.

[For text of subds 1 and 2, see M.S.2000]

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) nonrefundable base certification fee, $1,200; and

(2) test category certification fees:

Test Category	Certification Fee
Clean water program bacteriology	$600
Safe drinking water program bacteriology	$600
Clean water program inorganic chemistry	$600
Safe drinking water program inorganic chemistry	$600
Clean water program chemistry metals	$800
Safe drinking water program chemistry metals	$800
Resource conservation and recovery program chemistry metals	$800
Clean water program volatile organic compounds	$1,200
Safe drinking water program volatile organic compounds	$1,200
Resource conservation and recovery program volatile organic compounds	$1,200
Underground storage tank program volatile organic compounds	$1,200
Clean water program other organic compounds	$1,200

Safe drinking water program other organic compounds	$1,200
Resource conservation and recovery program other organic compounds	$1,200

(b) The total biennial certification fee is the base fee plus the applicable test category fees.

(c) Laboratories located outside of this state that require an on-site survey will be assessed an additional $2,500 fee.

(d) 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.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is $500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

[For text of subds 4 and 5, see M.S.2000]

History: *1Sp2001 c 9 art 1 s 38*

144.994 [Repealed, 2001 c 171 s 14]