Senate Language S1458-2

House Language UES1458-1

ARTICLE 7
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2014, section 13.3806, subdivision 4, is amended to read:

Subd. 4. **Vital statistics.** (a) **Parents' Social Security number; birth record.** Parents' Social Security numbers and certain contact information provided for a child's birth record are classified under section 144.215, subdivision 4, or 4a.

(b) **Foundling registration.** The report of the finding of an infant of unknown parentage is classified under section 144.216, subdivision 2.

(c) **New record of birth.** In circumstances in which a new record of birth may be issued under section 144.218, the original record of birth is classified as provided in that section.

(d) **Vital records.** Physical access to vital records is governed by section 144.225, subdivision 1.

(e) **Birth record of child of unmarried parents.** Access to the birth record of a child whose parents were not married to each other when the child was conceived or born is governed by sections 144.225, subdivisions 2 and 4, and 257.73.

(f) **Health data for birth registration.** Health data collected for birth registration or fetal death reporting are classified under section 144.225, subdivision 2a.

(g) **Birth record; sharing.** Sharing of birth record data and data prepared under section 257.75, is governed by section 144.225, subdivision 2b.

(h) **Group purchaser identity for birth registration.** Classification of and access to the identity of a group purchaser collected in association with birth registration is governed by section 144.225, subdivision 6.

Sec. 2. **[15.445] RETAIL FOOD ESTABLISHMENT FEES.**

Subdivision 1. **Fees.** The fees in this section are required for food and beverage service establishments licensed under chapter 157. Food and beverage service establishments must pay the applicable fee under subdivision 2, paragraph (a), (b), (c), or (d), and all applicable fees under subdivision 4. Temporary food establishments and special events must pay the applicable fee under subdivision 3.

Subd. 2. **Permanent food establishments.** (a) The Category 1 establishment license fee is $210 annually. "Category 1 establishment" means an establishment that does one or more of the following:

(1) sells only prepackaged nonpotentially hazardous foods as defined in Minnesota Rules, chapter 4626;

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(2) provides cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off-site; or

(3) operates a childcare facility licensed under section 245A.03 and Minnesota Rules, chapter 9503.

(b) The Category 2 establishment license fee is $270 annually. "Category 2 establishment" means an establishment that is not a Category 1 establishment and is either:

(1) a food establishment where the method of food preparation meets the definition of a low-risk establishment in section 157.20; or

(2) an elementary or secondary school as defined in section 120A.05.

(c) The Category 3 establishment license fee is $460 annually. "Category 3 establishment" means an establishment that is not a Category 1 or 2 establishment and the method of food preparation meets the definition of a medium-risk establishment in section 157.20.

(d) The Category 4 establishment license fee is $690 annually. "Category 4 establishment" means an establishment that is not a Category 1, 2, or 3 establishment and is either:

(1) a food establishment where the method of food preparation meets the definition of a high-risk establishment in section 157.20; or

(2) an establishment where 500 or more meals per day are prepared at one location and served at one or more separate locations.

Subd. 3. **Temporary food establishments and special events.** (a) The special event food stand license fee is $50 annually. Special event food stand is where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(b) The temporary food and beverage service license fee is $210 annually. A temporary food and beverage service includes food carts, mobile food units, seasonal temporary food stands, retail food vehicles, portable structures, and seasonal permanent food stands.

Subd. 4. **Additional applicable fees.** (a) The individual private sewer or individual private water license fee is $60 annually. Individual private water is a water supply other than a community public water supply as covered in Minnesota Rules, chapter 4720. Individual private sewer is an individual sewage treatment system which uses subsurface treatment and disposal.

(b) The additional food or beverage service license fee is $165 annually. Additional food or beverage service is a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food or beverages to the public. Additional food service does not apply to school concession stands.

(c) The specialized processing license fee is $400 annually. Specialized processing is a business that performs one or more specialized processes that require a HACCP as required in Minnesota Rules, chapter 4626.

Sec. 3. Minnesota Statutes 2014, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

~~(c) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund after the transfer required in paragraph (a), effective for the biennium beginning July 1, 2013, the commissioner of management and budget shall transfer $1,000,000 each fiscal year from the health access fund to the medical education and research costs fund established under section 62J.692, for distribution under section 62J.692, subdivision 4, paragraph (c).~~

Sec. 4. Minnesota Statutes 2014, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a state-certified health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(a)~~ (b) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

~~(b)~~ (c) "Commissioner" means the commissioner of health.

~~(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.~~

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the ~~infrastructure~~ technical capabilities or related products and services to ~~connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including~~ enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j). This includes but is not limited to: health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495. ~~This does not include health care providers engaged in direct health information exchange.~~

(f) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization ~~that has been issued a certificate of authority by the commissioner under section 62J.4981~~.

(h) "Health information organization" means an organization that oversees, governs, and facilitates ~~the~~ health information exchange ~~of health-related information~~ among ~~organizations according to nationally recognized standards~~ health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j), to improve coordination of patient care and the efficiency of health care delivery.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

(k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a state-certified health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (j). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(k)~~ (l) "Meaningful use" means use of certified electronic health record technology ~~that includes e-prescribing, and is connected in a manner that provides for the electronic exchange of health information and used for the submission of clinical quality measures~~ to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

~~(l)~~ (m) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

~~(m)~~ (n) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health data intermediary has contracts or other agreements for the provision of health information exchange ~~service providers~~ services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(n)~~ (o) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of ~~meaningful use~~ clinical transactions.

~~(o)~~ (p) "State-certified health data intermediary" means a health data intermediary that~~:~~ has been issued a certificate of authority to operate in Minnesota.

~~(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;~~

~~(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and~~

~~(3) has been issued a certificate of authority to operate in Minnesota.~~

~~(p)~~ (q) "State-certified health information organization" means a ~~nonprofit~~ health information organization that ~~provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that~~ has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) ~~hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall~~ make all portions of the application classified as public data available to the public for at least ten days ~~in advance of the hearing~~ while an application is under consideration. At the request of the commissioner, the applicant shall participate in ~~the~~ a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) ~~make available all feedback and recommendations gathered at the hearing available to the public prior to issuing a certificate of authority; and~~

~~(3)~~ consult with hospitals, physicians, and other ~~professionals eligible to receive meaningful use incentive payments or subject to penalties as established in the HITECH Act, and their respective statewide associations,~~ providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 5. Minnesota Statutes 2014, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~an entity providing health information exchange services~~ a health data intermediary or a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information ~~organization~~ exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary ~~that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use~~ must be ~~registered with~~ certified by the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

~~(1) interoperate with at least one state-certified health information organization;~~

~~(2) provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;~~

~~(3) have a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and~~

~~(4)~~ (1) hold reciprocal agreements with at least one state-certified health information organization to ~~enable~~ access ~~to record locator services to find~~ patient data, and for the transmission and receipt of ~~meaningful use~~ clinical transactions ~~consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services~~. Reciprocal agreements must meet the requirements established in subdivision 5~~.~~; and

(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.

Subd. 3. **Certificate of authority for health information organizations.**
(a) A health information organization ~~that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records~~ must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, ~~a nonprofit corporation organized to do so~~ an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established~~, nonprofit~~ organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans ~~clearly~~ address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand ~~technical capacity of the health information organization~~ to support providers in achieving ~~meaningful use of electronic health records~~ health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information ~~organizations~~ exchange service providers for ~~meaningful use~~ clinical transactions, compliance with Minnesota law, and interstate health information exchange ~~in~~ trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with ~~criteria established under the Health Information Exchange Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC) or equivalent criteria established~~ national certification and accreditation programs designated by the commissioner;

(8) the entity maintains ~~a~~ the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (i)~~, that is~~. The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting ~~meaningful use~~ clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the ~~Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation~~ National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

~~(i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and~~

~~(ii)~~ (i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

~~(3) develop and maintain a business plan that addresses:~~

~~(i)~~ (ii) plans for ensuring the necessary capacity to support ~~meaningful use~~ clinical transactions;

~~(ii)~~ (iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

~~(iii)~~ (iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

~~(iv)~~ (v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

~~(4) annually submit a rate plan to the commissioner outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:~~

~~(i) distributes costs equitably among users of health information services;~~

~~(ii) provides predictable costs for participating entities;~~

~~(iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and~~

~~(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;~~

~~(5)~~ (3) enter into reciprocal agreements with all other state-certified health information organizations and state-certified health data intermediaries to enable access to ~~record locator services to find~~ patient data, and for the transmission and receipt of ~~meaningful use~~ clinical transactions ~~consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services~~. Reciprocal agreements must meet the requirements in subdivision 5; ~~and~~

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries; and

~~(6)~~ (5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in subdivisions 2 and 3:

(1) for health information organizations only, a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) for health information organizations only, a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) for health information organizations only, the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~organization~~ exchange service provider. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

~~(5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;~~

~~(6)~~ (5) a statement generally describing the health information ~~organization~~ exchange service provider, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

~~(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;~~

~~(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;~~

~~(9)~~ (6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

~~(10)~~ (7) a description of the complaint procedures to be used as required under this section;

~~(11)~~ (8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

~~(12)~~ (9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

~~(13)~~ (10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

~~(14)~~ (11) other information as the commissioner may reasonably require to be provided.

(b) Within ~~30~~ 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization or state-certified health data intermediary, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information exchange entities.** (a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions ~~necessary to achieve meaningful use~~;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use transactions.

~~(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.~~

~~Subd. 6. **State participation in health information exchange.** A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency as necessary for meaningful use by the participating entities of the other health information service providers.~~

Sec. 6. Minnesota Statutes 2014, section 62J.4982, subdivision 4, is amended to read:

Subd. 4. **Coordination.** ~~(a)~~ The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers when implementing sections 62J.498 to 62J.4982.

~~(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.~~

Sec. 7. Minnesota Statutes 2014, section 62J.4982, subdivision 5, is amended to read:

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information exchange service provider subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, ~~$10,500~~ $7,000;

(2) filing an application for certificate of authority to operate as a health data intermediary, $7,000;

(3) annual health information organization certificate fee, ~~$14,000~~ $7,000; and

(4) annual health data intermediary certificate fee, $7,000~~; and~~

~~(5) fees for other filings, as specified by rule~~.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

~~(b)~~ (c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 8. Minnesota Statutes 2014, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the available medical education funds to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students. Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph.

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(b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).

(c) ~~Of available medical education funds, $1,000,000 shall be distributed each year for grants to family medicine residency programs located outside the seven-county metropolitan area, as defined in section 473.121, subdivision 4, focused on eduction and training of family medicine physicians to serve communities outside the metropolitan area. To be eligible for a grant under this paragraph, a family medicine residency program must demonstrate that over the most recent three calendar years, at least 25 percent of its residents practice in Minnesota communities outside the metropolitan area. Grant funds must be allocated proportionally based on the number of residents per eligible residency program.~~

~~(d)~~ Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(e)~~ (d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(f)~~ (e) Use of funds is limited to expenses related to clinical training program costs for eligible programs.

~~(g)~~ (f) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(h)~~ (g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 9. Minnesota Statutes 2014, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations; ~~and~~

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities~~.~~; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by Web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

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(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2016.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

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Sec. 4. Minnesota Statutes 2014, section 103I.205, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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178.33 (3) installing well pumps or pumping equipment;

178.34 (4) sealing wells;

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

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

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

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

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

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

179.14 (3) a licensed plumber who is repairing submersible pumps or water pipes associated
179.15 with well water systems if:

179.16 (i) the repair location is within an area where there is no licensed or registered
179.17 well contractor within ~~25~~ 50 miles; and

179.18 (ii) the licensed plumber complies with all of the requirements of this chapter and
179.19 all relevant sections of the plumbing code.

236.25 Sec. 10. Minnesota Statutes 2014, section 144.1501, subdivision 1, is amended to read:

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

236.28 (b) "Advanced dental therapist" means an individual who is licensed as a dental
236.29 therapist under section 150A.06, and who is certified as an advanced dental therapist
236.30 under section 150A.106.

236.31 (c) "Dental therapist" means an individual who is licensed as a dental therapist
236.32 under section 150A.06.

236.33 ~~(b)~~ (d) "Dentist" means an individual who is licensed to practice dentistry.

236.34 ~~(c)~~ (e) "Designated rural area" means a statutory and home rule charter city or
236.35 township that is~~:~~

~~(1)~~ outside the seven-county metropolitan area as defined in section 473.121, subdivision 2~~; and~~, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

~~(2) has a population under 15,000.~~

~~(d)~~ (f) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(g) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

~~(e)~~ (h) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(f)~~ (i) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(g)~~ (j) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(h)~~ (k) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(i)~~ (l) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(j)~~ (m) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(k)~~ (n) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(l)~~ (o) "Physician assistant" means a person licensed under chapter 147A.

(p) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(m)~~ (q) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(n)~~ (r) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 11. Minnesota Statutes 2014, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home ~~or~~; an intermediate care facility for persons with developmental disability; or a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters 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.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 12. Minnesota Statutes 2014, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident~~,~~; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse ~~training program~~ . The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health. ~~If fewer applications are submitted by dental students or residents than there are dentist participant slots available, the commissioner may consider applications submitted by dental program graduates who are licensed dentists.~~

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 13. Minnesota Statutes 2014, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. In considering applications, the commissioner shall give preference to applicants who document diverse cultural competencies. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference 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

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annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 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 2.

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Sec. 5. **[144.1506] PRIMARY CARE RESIDENCY EXPANSION GRANT PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible primary care residency program" means a program that meets the following criteria:

(i) is located in Minnesota;

(ii) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

(iii) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation;

(2) "eligible project" means a project to establish a new eligible primary care residency program or create at least one new residency slot in an existing eligible primary care residency program; and

(3) "new residency slot" means the creation of a new residency position and the execution of a contract with a new resident in a residency program.

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

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(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new family medicine resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications for expansion grants.** Eligible primary care residency programs seeking a grant shall apply to the commissioner. Applications must include the number of new family medicine residency slots planned or under contract; attestation that funding will be used to support an increase in the number of available residency slots; a description of the training to be received by the new residents, including the location of training; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; and a plan to maintain the new residency slot after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; four psychiatry residents; two geriatrics residents; and two general surgery residents. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

Sec. 14. **[144.1911] INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.**

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

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

(b) "Commissioner" means the commissioner of health.

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that: (1) is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2; and (2) has a population under 15,000.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. **Program administration.** (a) In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. **Career guidance and support services.** (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. **Voluntary hospital programs.** A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. **Board of Medical Practice.** Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. **Consultation with stakeholders.** The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:

(i) organizations serving immigrant and refugee communities of Minnesota;

(ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and

(iii) the Minnesota Association of Community Health Centers;

(4) higher education:

(i) University of Minnesota;

(ii) Mayo Clinic School of Health Professions;

(iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and

(iv) Minnesota physician assistant education program; and

(5) two international medical graduates.

Subd. 10. **Report.** The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

Sec. 15. Minnesota Statutes 2014, section 144.215, is amended by adding a subdivision to read:

Subd. 4a. **Parent contact information.** The mailing or residence address, other than the city or county, e-mail address, and telephone number of a parent provided in connection with the electronic registration of a birth or application for a birth certificate are private data on individuals, provided that the data may be disclosed to a school or a local, state, tribal, or federal government entity to the extent that the data are necessary for the entity to perform its duties.

Sec. 16. Minnesota Statutes 2014, section 144.225, subdivision 4, is amended to read:

Subd. 4. **Access to records for research purposes.** The state registrar may permit persons performing medical research access to the information restricted in subdivision 2 or 2a, or section 144.215, subdivision 4a, if those persons agree in writing not to disclose private or confidential data on individuals.

Sec. 17. Minnesota Statutes 2014, section 144.291, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(b) "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

(c) "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

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

(f) "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

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(g) "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 according 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 under 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.

(h) "Patient information service" means a service providing the following query options: a record locator service as defined in section 144.291, subdivision 2, paragraph (i), or a master patient index or clinical data repository as defined in section 62J.498, subdivision 1.

~~(h)~~ (i) "Provider" means:

(1) any person who furnishes health care services and is regulated to furnish the services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148D, 148F, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section ~~144A.46~~ 144A.471;

(3) a health care facility licensed under this chapter or chapter 144A; and

(4) a physician assistant registered under chapter 147A.

~~(i)~~ (j) "Record locator service" means an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers.

~~(j)~~ (k) "Related health care entity" means an affiliate, as defined in section 144.6521, subdivision 3, paragraph (b), of the provider releasing the health records.

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Sec. 6. Minnesota Statutes 2014, section 144.293, subdivision 5, is amended to read:

Subd. 5. **Exceptions to consent requirement.** (a) This section does not prohibit the release of health records:

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

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

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

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181.14 (i) is returning to the health care facility and unable to provide consent; or

181.15 (ii) who resides in the health care facility, has services provided by an outside
181.16 resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable
181.17 to provide consent.

181.18 (b) A provider may release a deceased patient's health care records to another provider
181.19 for the purposes of diagnosing or treating the deceased patient's surviving adult child.

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

247.8 Sec. 18. Minnesota Statutes 2014, section 144.293, subdivision 8, is amended to read:

247.9 Subd. 8. **Record locator or patient information service.** (a) A provider or group
247.10 purchaser may release patient identifying information and information about the location
247.11 of the patient's health records to a record locator or patient information service without
247.12 consent from the patient, unless the patient has elected to be excluded from the service
247.13 under paragraph (d). The Department of Health may not access the record locator or
247.14 patient information service or receive data from the ~~record locator~~ service. Only a
247.15 provider may have access to patient identifying information in a record locator or patient
247.16 information service. Except in the case of a medical emergency, a provider participating in
247.17 a health information exchange using a record locator or patient information service does
247.18 not have access to patient identifying information and information about the location of
247.19 the patient's health records unless the patient specifically consents to the access. A consent
247.20 does not expire but may be revoked by the patient at any time by providing written notice
247.21 of the revocation to the provider.

247.22 (b) A health information exchange maintaining a record locator or patient
247.23 information service must maintain an audit log of providers accessing information in ~~a~~
247.24 ~~record locator~~ the service that at least contains information on:

247.25 (1) the identity of the provider accessing the information;

247.26 (2) the identity of the patient whose information was accessed by the provider; and

247.27 (3) the date the information was accessed.

247.28 (c) No group purchaser may in any way require a provider to participate in a record
247.29 locator or patient information service as a condition of payment or participation.

(d) A provider or an entity operating a record locator or patient information service must provide a mechanism under which patients may exclude their identifying information and information about the location of their health records from a record locator or patient information service. At a minimum, a consent form that permits a provider to access a record locator or patient information service must include a conspicuous check-box option that allows a patient to exclude all of the patient's information from the ~~record locator~~ service. A provider participating in a health information exchange with a record locator or patient information service who receives a patient's request to exclude all of the patient's information from the ~~record locator~~ service or to have a specific provider contact excluded from the ~~record locator~~ service is responsible for removing that information from the ~~record locator~~ service.

Sec. 19. Minnesota Statutes 2014, section 144.298, subdivision 2, is amended to read:

Subd. 2. **Liability of provider or other person.** A person who does any of the following is liable to the patient for compensatory damages caused by an unauthorized release or an intentional, unauthorized access, plus costs and reasonable attorney fees:

(1) negligently or intentionally requests or releases a health record in violation of sections 144.291 to 144.297;

(2) forges a signature on a consent form or materially alters the consent form of another person without the person's consent;

(3) obtains a consent form or the health records of another person under false pretenses; or

(4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a record locator or patient information service without authorization.

Sec. 20. Minnesota Statutes 2014, section 144.298, subdivision 3, is amended to read:

Subd. 3. **Liability for record locator or patient information service.** A patient is entitled to receive compensatory damages plus costs and reasonable attorney fees if a health information exchange maintaining a record locator or patient information service, or an entity maintaining a record locator or patient information service for a health information exchange, negligently or intentionally violates the provisions of section 144.293, subdivision 8.

Sec. 21. Minnesota Statutes 2014, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $8.28 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 22. **[144.3875] EARLY DENTAL PREVENTION INITIATIVE.**

(a) The commissioner of health, in collaboration with the commissioner of human services, shall implement a statewide initiative to increase awareness among communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear.

(b) The commissioner shall develop educational materials and information for expectant and new parents within the targeted communities that include the importance of early dental care to prevent early cavities, including proper cleaning techniques and feeding habits, before and after primary teeth appear.

(c) The commissioner shall develop a distribution plan to ensure that the materials are distributed to expectant and new parents within the targeted communities, including, but not limited to, making the materials available to health care providers, community clinics, WIC sites, and other relevant sites within the targeted communities.

(d) In developing these materials and distribution plan, the commissioner shall work collaboratively with members of the targeted communities, dental providers, pediatricians, child care providers, and home visiting nurses.

(e) The commissioner shall, with input from stakeholders listed in paragraph (d), develop and pilot incentives to encourage early dental care within one year of an infant's teeth erupting.

Sec. 23. **[144.4961] MINNESOTA RADON LICENSING ACT.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules for licensure and enforcement of applicable laws and rules relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after October 1, 2017, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** A license is required annually for every person, firm, or corporation that sells a device or performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere. This section does not apply to retail stores that only sell or distribute radon sampling but are not engaged in the manufacture of radon sampling devices.

Subd. 6. **Exemptions.** Radon systems installed in newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy are not required to follow the requirements of this section.

Subd. 7. **License applications and other reports.** The professionals, companies, and laboratories listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, $300 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building they do not own or lease; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; or makes representations of doing any of these activities.

(2) Each mitigation professional license, $500 per year. "Mitigation professional" means an individual who performs radon mitigation in a building they do not own or lease; provides professional or expert advice on radon mitigation or radon entry routes; or provides on-site supervision of radon mitigation and mitigation technicians; or makes representations of doing any of these activities. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, $500 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the company is a sole proprietorship.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective October 1, 2017.

Sec. 24. **[144.566] VIOLENCE AGAINST HEALTH CARE WORKERS.**

Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have the meanings given.

(b) "Act of violence" means an act by a patient or visitor against a health care worker that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections 609.221 to 609.2241.

(c) "Commissioner" means the commissioner of health.

(d) "Health care worker" means any person, whether licensed or unlicensed, employed by, volunteering in, or under contract with a hospital, who has direct contact with a patient of the hospital for purposes of either medical care or emergency response to situations potentially involving violence.

(e) "Hospital" means any facility licensed as a hospital under section 144.55.

(f) "Incident response" means the actions taken by hospital administration and health care workers during and following an act of violence.

(g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's ability to report acts of violence, including by retaliating or threatening to retaliate against a health care worker.

(h) "Preparedness" means the actions taken by hospital administration and health care workers to prevent a single act of violence or acts of violence generally.

(i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against, or penalize a health care worker regarding the health care worker's compensation, terms, conditions, location, or privileges of employment.

Subd. 2. **Hospital duties.** (a) All hospitals must design and implement preparedness and incident response action plans to acts of violence by January 15, 2016, and review the plan at least annually thereafter.

(b) A hospital shall designate a committee of representatives of health care workers employed by the hospital, including nonmanagerial health care workers, nonclinical staff, administrators, patient safety experts, and other appropriate personnel to develop preparedness and incident response action plans to acts of violence. The hospital shall, in consultation with the designated committee, implement the plans under paragraph (a). Nothing in this paragraph shall require the establishment of a separate committee solely for the purpose required by this subdivision.

(c) A hospital shall provide training to all health care workers employed or contracted with the hospital on safety during acts of violence. Each health care worker must receive safety training annually and upon hire. Training must, at a minimum, include:

(1) safety guidelines for response to and de-escalation of an act of violence;

(2) ways to identify potentially violent or abusive situations; and

(3) the hospital's incident response reaction plan and violence prevention plan.

(d) As part of its annual review required under paragraph (a), the hospital must review with the designated committee:

(1) the effectiveness of its preparedness and incident response action plans;

(2) the most recent gap analysis as provided by the commissioner; and

(3) the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred.

(e) A hospital shall make its action plans and the information listed in paragraph (d) available to local law enforcement and, if any of its workers are represented by a collective bargaining unit, to the exclusive bargaining representatives of those collective bargaining units.

(f) A hospital, including any individual, partner, association, or any person or group of persons acting directly or indirectly in the interest of the hospital, shall not interfere with or discourage a health care worker if the health care worker wishes to contact law enforcement or the commissioner regarding an act of violence.

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(g) The commissioner may impose an administrative fine of up to $250 for failure to comply with the requirements of subdivision 2.

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Sec. 7. **[144.586] REQUIREMENTS FOR CERTAIN NOTICES AND DISCHARGE PLANNING.**

Subdivision 1. **Observation stay notice.** (a) Each hospital, as defined under section 144.50, subdivision 2, shall provide oral and written notice to each patient that the hospital places in observation status of such placement not later than 24 hours after such placement. The oral and written notices must include:

(1) a statement that the patient is not admitted to the hospital but is under observation status;

(2) a statement that observation status may affect the patient's Medicare coverage for:

(i) hospital services, including medications and pharmaceutical supplies; or

(ii) home or community-based care or care at a skilled nursing facility upon the patient's discharge; and

(3) a recommendation that the patient contact the patient's health insurance provider or the Office of the Ombudsman for Long-Term Care or Office of the Ombudsman for State Managed Health Care Programs or the Beneficiary and Family Centered Care Quality Improvement Organization to better understand the implications of placement in observation status.

(b) The hospital shall document the date in the patient's record that the notice required in paragraph (a) was provided to the patient, the patient's designated representative such as the patient's health care agent, legal guardian, conservator, or another person acting as the patient's representative.

Subd. 2. **Postacute care discharge planning.** Each hospital, including hospitals designated as critical access hospitals, must comply with the federal hospital requirements for discharge planning which include:

(1) conducting a discharge planning evaluation that includes an evaluation of:

(i) the likelihood of the patient needing posthospital services and of the availability of those services; and

(ii) the patient's capacity for self-care or the possibility of the patient being cared for in the environment from which the patient entered the hospital;

(2) timely completion of the discharge planning evaluation under clause (1) by hospital personnel so that appropriate arrangements for posthospital care are made before discharge, and to avoid unnecessary delays in discharge;

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(3) including the discharge planning evaluation under clause (1) in the patient's medical record for use in establishing an appropriate discharge plan. The hospital must discuss the results of the evaluation with the patient or individual acting on behalf of the patient. The hospital must reassess the patient's discharge plan if the hospital determines that there are factors that may affect continuing care needs or the appropriateness of the discharge plan; and

(4) providing counseling, as needed, for the patient and family members or interested persons to prepare them for posthospital care. The hospital must provide a list of available Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's geographic area, or other area requested by the patient if such care or placement is indicated and appropriate. Once the patient has designated their preferred providers, the hospital will assist the patient in securing care covered by their health plan or within the care network. The hospital must not specify or otherwise limit the qualified providers that are available to the patient. The hospital must document in the patient's record that the list was presented to the patient or to the individual acting on the patient's behalf.

Sec. 8. **[144.611] CAPTIONING REQUIRED.**

(a) This section applies to health care facilities licensed under this chapter.

(b) Any television in a waiting room provided for use by the general public, or by individuals using or requesting services, must have a closed captioning feature activated at all times, if the television includes a captioning feature. A health care facility must make reasonable efforts to prevent members of the general public and individuals using or requesting services from independently deactivating a captioning feature.

(c) It is not a violation of this section if the captioning feature is deactivated by a member of the general public or an individual using or requesting services, so long as the captioning is reactivated as soon as possible by a member of the facility staff upon knowledge that the deactivation has occurred.

(d) Failure to provide captioning consistent with this section is a violation of section 363A.11.

Sec. 25. Minnesota Statutes 2014, section 144.9501, subdivision 6d, is amended to read:

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

Sec. 26. Minnesota Statutes 2014, section 144.9501, is amended by adding a subdivision to read:

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

Sec. 27. Minnesota Statutes 2014, section 144.9501, subdivision 22b, is amended to read:

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for renovation sites and lead dust sampling for nonabatement sites~~, and who is registered with the commissioner under section 144.9505~~.

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

Sec. 28. Minnesota Statutes 2014, section 144.9501, subdivision 26b, is amended to read:

Subd. 26b. **Renovation.** "Renovation" means the modification of any pre-1978 affected property that results in the disturbance of known or presumed lead-containing painted surfaces defined under section 144.9508, unless that activity is performed as ~~an abatement~~ lead hazard reduction. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

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

Sec. 29. Minnesota Statutes 2014, section 144.9501, is amended by adding a subdivision to read:

Subd. 26c. **Lead renovator.** "Lead renovator" means an individual who directs individuals who perform renovations. A lead renovator also performs renovation, surface coating testing, and cleaning verification.

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

Sec. 30. Minnesota Statutes 2014, section 144.9505, is amended to read:

144.9505 ~~LICENSING~~ CREDENTIALING OF LEAD FIRMS AND PROFESSIONALS.

Subdivision 1. **Licensing ~~and~~, certification~~; generally~~, and permitting.** (a) ~~All~~ Fees ~~received shall be paid~~ collected under this section shall be deposited 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~~ state government special revenue fund.

(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~~ renovation firms, 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~~ lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, clearance inspections, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders 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~~ individuals, 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 annually 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 annually 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 annually 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 annually 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 annually 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 who employs individuals to perform regulated lead work, with the exception of renovation, outside of the person's property must obtain certification as a lead firm. 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. A lead firm certificate is valid for one year. The certification fee is $100, is nonrefundable, and must be submitted with each application. The lead firm 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. 1h. **Certified renovation firm.** A person who employs individuals to perform renovation activities outside of the person's property must obtain certification as a renovation firm. 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. A renovation firm certificate is valid for two years. The certification fee is $100, is nonrefundable, and must be submitted with each application. The renovation firm 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. 1i. **Lead training course.** Before a person provides training to lead workers, lead supervisors, lead inspectors, lead risk assessors, lead project designers, lead sampling technicians, and lead renovators, the person shall first obtain a permit from the commissioner. The permit 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. A training course permit is valid for two years. 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. 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 326B.805. 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, renovation, or lead project design activities.

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 144.9512 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 144.9512.

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

Sec. 31. Minnesota Statutes 2014, section 144.9508, is amended to read:

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 reduction 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 144.9512.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

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Subd. 2a. **Lead standards for exterior surfaces and street dust.** The commissioner may, by rule, establish lead standards for exterior horizontal surfaces, concrete or other impervious surfaces, and street dust on residential property to protect the public health and the environment.

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

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

Sec. 32. **[144.999] LIFE-SAVING ALLERGY MEDICATION.**

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

(b) "Administer" means the direct application of an epinephrine auto-injector to the body of an individual.

(c) "Authorized entity" means entities that fall in the categories of recreation camps, colleges and universities, preschools and daycares, and any other category of entities or organizations that the commissioner authorizes to obtain and administer epinephrine auto-injectors without a prescription. This definition does not include a school covered under section 121A.2207.

(d) "Commissioner" means the commissioner of health.

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Sec. 9. **[144.999] LIFE-SAVING ALLERGY MEDICATION.**

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

(b) "Administer" means the direct application of an epinephrine auto-injector to the body of an individual.

(c) "Authorized entity" means entities that fall in the categories of recreation camps, colleges and universities, preschools and day cares, and any other category of entities or organizations that the commissioner authorizes to obtain and administer epinephrine auto-injectors pursuant to this section. This definition does not include a school covered under section 121A.2207.

(d) "Commissioner" means the commissioner of health.

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(e) "Epinephrine auto-injector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(f) "Provide" means to supply one or more epinephrine auto-injectors to an individual or the individual's parent, legal guardian, or caretaker.

Subd. 2. **Commissioner duties.** The commissioner may identify additional categories of entities or organizations to be authorized entities if the commissioner determines that individuals may come in contact with allergens capable of causing anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the categories of authorized entities and may authorize additional categories of authorized entities as the commissioner deems appropriate. The commissioner may contract with a vendor to perform the review and identification of authorized entities.

Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors to be provided or administered to an individual if, in good faith, an owner, manager, employee, or agent of an authorized entity believes that the individual is experiencing anaphylaxis regardless of whether the individual has a prescription for an epinephrine auto-injector. The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine.

(b) An authorized entity may obtain epinephrine auto-injectors from pharmacies licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an epinephrine auto-injector, an owner, manager, or authorized agent of the entity must present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

(c) An authorized entity shall store epinephrine auto-injectors in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the commissioner. An authorized entity shall designate employees or agents who have completed the training program required under subdivision 5 to be responsible for the storage, maintenance, and control of epinephrine auto-injectors obtained and possessed by the authorized entity.

Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or agent of an authorized entity who has completed the training required under subdivision 5 may:

(1) provide an epinephrine auto-injector for immediate administration to an individual or the individual's parent, legal guardian, or caregiver if the owner, manager, employee, or agent believes, in good faith, the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy; or

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(e) "Epinephrine auto-injector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(f) "Provide" means to supply one or more epinephrine auto-injectors to an individual or the individual's parent, legal guardian, or caretaker.

Subd. 2. **Commissioner duties.** The commissioner may identify additional categories of entities or organizations to be authorized entities if the commissioner determines that individuals may come in contact with allergens capable of causing anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the categories of authorized entities and may authorize additional categories of authorized entities as the commissioner deems appropriate. The commissioner may contract with a vendor to perform the review and identification of authorized entities.

Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors to be provided or administered to an individual if, in good faith, an employee or agent of an authorized entity believes that the individual is experiencing anaphylaxis regardless of whether the individual has a prescription for an epinephrine auto-injector. The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine.

(b) An authorized entity may obtain epinephrine auto-injectors from pharmacies licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an epinephrine auto-injector, an owner, manager, or authorized agent of the entity must present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

(c) An authorized entity shall store epinephrine auto-injectors in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the commissioner. An authorized entity shall designate employees or agents who have completed the training program required under subdivision 5 to be responsible for the storage, maintenance, and control of epinephrine auto-injectors obtained and possessed by the authorized entity.

Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or agent of an authorized entity who has completed the training required under subdivision 5 may:

(1) provide an epinephrine auto-injector for immediate administration to an individual or the individual's parent, legal guardian, or caregiver if the employee or agent believes, in good faith, the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy; or

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(2) administer an epinephrine auto-injector to an individual who the owner, manager, employee, or agent believes, in good faith, is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(b) Nothing in this section shall be construed to require any authorized entity to maintain a stock of epinephrine auto-injectors.

Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized under subdivision 4, an individual must complete, every two years, an anaphylaxis training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment, a statewide organization with experience providing training on allergies and anaphylaxis under the supervision of board-certified allergy medical advisors, or an entity or individual approved by the commissioner to provide an anaphylaxis training program. The commissioner may approve specific entities or individuals to conduct the training program or may approve categories of entities or individuals to conduct the training program. Training may be conducted online or in person and, at a minimum, must cover:

(1) how to recognize signs and symptoms of severe allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage and administration of an epinephrine auto-injector; and

(3) emergency follow-up procedures.

(b) The entity or individual conducting the training shall issue a certificate to each person who successfully completes the anaphylaxis training program. The commissioner may develop, approve, and disseminate a standard certificate of completion. The certificate of completion shall be valid for two years from the date issued.

Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to this section by an authorized entity that possesses and makes available epinephrine auto-injectors and its employees or agents, a pharmacy or manufacturer that dispenses epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts the training described in subdivision 5 is considered "emergency care, advice, or assistance" under section 604A.01.

Sec. 33. Minnesota Statutes 2014, section 144A.70, subdivision 6, is amended to read:

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(2) administer an epinephrine auto-injector to an individual who the employee or agent believes, in good faith, is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(b) Nothing in this section shall be construed to require any authorized entity to maintain a stock of epinephrine auto-injectors.

Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized under subdivision 4, an individual must complete, every two years, an anaphylaxis training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment, a statewide organization with experience providing training on allergies and anaphylaxis under the supervision of board-certified allergy medical advisors, or an entity or individual approved by the commissioner to provide an anaphylaxis training program. The commissioner may approve specific entities or individuals to conduct the training program or may approve categories of entities or individuals to conduct the training program. Training may be conducted online or in person and, at a minimum, must cover:

(1) how to recognize signs and symptoms of severe allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage and administration of an epinephrine auto-injector; and

(3) emergency follow-up procedures.

(b) The entity or individual conducting the training shall issue a certificate to each person who successfully completes the anaphylaxis training program. The commissioner may develop, approve, and disseminate a standard certificate of completion. The certificate of completion shall be valid for two years from the date issued.

Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to this section by an authorized entity that possesses and makes available epinephrine auto-injectors and its employees or agents, a pharmacy or manufacturer that dispenses epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts the training described in subdivision 5 is considered "emergency care, advice, or assistance" under section 604A.01.

Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, ~~and~~ orderlies, and other licensed health professionals. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency does not include a professional home care agency licensed ~~as a Class A provider~~ under section ~~144A.46 and rules adopted thereunder~~ 144A.471 that only provides staff to other home care providers.

Sec. 34. Minnesota Statutes 2014, section 144A.70, is amended by adding a subdivision to read:

Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental nursing services agencies through annual unannounced surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions necessary to ensure compliance with sections 144A.70 to 144A.74.

Sec. 35. Minnesota Statutes 2014, section 144A.71, is amended to read:

144A.71 SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.

Subdivision 1. **Duty to register.** A person who operates a supplemental nursing services agency shall register ~~the agency~~ annually with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration. Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 2. **Application information and fee.** The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

(1) the names and addresses of the owner or owners of the supplemental nursing services agency;

(2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;

(3) satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to (7);

(4) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; ~~and~~

(5) ~~the annual registration fee for a supplemental nursing services agency, which is $891.~~ a policy and procedure that describes how the supplemental nursing services agency's records will be immediately available at all times to the commissioner; and

(6) a registration fee of $2,035.

If a supplemental nursing services agency fails to provide the items in this subdivision to the department, the commissioner shall immediately suspend or refuse to issue the supplemental nursing services agency registration. The supplemental nursing services agency may appeal the commissioner's findings according to section 144A.475, subdivisions 3a and 7, except that the hearing must be conducted by an administrative law judge within 60 calendar days of the request for hearing assignment.

Subd. 3. **Registration not transferable.** A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 36. Minnesota Statutes 2014, section 144A.72, is amended to read:

144A.72 REGISTRATION REQUIREMENTS; PENALTIES.

Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency;

(5) the supplemental nursing services agency shall carry an employee dishonesty bond in the amount of $10,000;

(6) the supplemental nursing services agency shall maintain insurance coverage for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided or procured by the agency;

(7) the supplemental nursing services agency shall file with the commissioner of revenue: (i) the name and address of the bank, savings bank, or savings association in which the supplemental nursing services agency deposits all employee income tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income is derived from placement by the agency, if the agency purports the income is not subject to withholding;

(8) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility; ~~and~~

(9) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities is an employee of the agency and is not an independent contractor~~.~~; and

(10) the supplemental nursing services agency shall retain all records for five calendar years. All records of the supplemental nursing services agency must be immediately available to the department.

(b) In order to retain registration, the supplemental nursing services agency must provide services to a health care facility during the year preceding the supplemental nursing services agency's registration renewal date.

Subd. 2. **Penalties.** ~~A pattern of~~ Failure to comply with this section shall subject the supplemental nursing services agency to revocation or nonrenewal of its registration. Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess of the maximum permitted under that section.

Subd. 3. **Revocation.** Notwithstanding subdivision 2, the registration of a supplemental nursing services agency that knowingly supplies to a health care facility a person with an illegally or fraudulently obtained or issued diploma, registration, license, certificate, or background study shall be revoked by the commissioner. The commissioner shall notify the supplemental nursing services agency 15 days in advance of the date of revocation.

Subd. 4. **Hearing.** (a) No supplemental nursing services agency's registration may be revoked without a hearing held as a contested case in accordance with ~~chapter 14. The hearing must commence within 60 days after the proceedings are initiated~~ section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

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(b) If a controlling person has been notified by the commissioner of health that the supplemental nursing services agency will not receive an initial registration or that a renewal of the registration has been denied, the controlling person or a legal representative on behalf of the supplemental nursing services agency may request and receive a hearing on the denial. ~~This~~ The hearing shall be ~~held as a contested case in accordance with chapter 14~~ a contested case in accordance with section 144A.475, subdivisions 3a and 7, except the hearing must be conducted by an administrative law judge within 60 calendar days of the request for assignment.

Subd. 5. **Period of ineligibility.** (a) The controlling person of a supplemental nursing services agency whose registration has not been renewed or has been revoked because of noncompliance with the provisions of sections 144A.70 to 144A.74 shall not be eligible to apply for nor will be granted a registration for five years following the effective date of the nonrenewal or revocation.

(b) The commissioner shall not issue or renew a registration to a supplemental nursing services agency if a controlling person includes any individual or entity who was a controlling person of a supplemental nursing services agency whose registration was not renewed or was revoked as described in paragraph (a) for five years following the effective date of nonrenewal or revocation.

Sec. 37. Minnesota Statutes 2014, section 144A.73, is amended to read:

144A.73 COMPLAINT SYSTEM.

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. ~~Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken~~ Complaints against a supplemental nursing services agency shall be investigated by the Office of Health Facility Complaints under Minnesota Statutes, sections 144A.51 to 144A.53.

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Sec. 10. Minnesota Statutes 2014, section 144A.75, subdivision 13, is amended to read:

Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a facility that resembles a single-family home located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

(b) Residential hospice facility also means a facility that directly provides 24-hour residential and support services for hospice patients and that:

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185.30 (1) houses no more than 21 hospice patients;

185.31 (2) meets hospice certification regulations adopted pursuant to title XVIII of the
185.32 federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

185.33 (3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a
185.34 40-bed non-Medicare certified nursing home as of January 1, 2015.

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

266.20 Sec. 38. Minnesota Statutes 2014, section 144D.01, is amended by adding a
266.21 subdivision to read:

266.22 Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who
266.23 provide home care services listed in section 144A.471, subdivisions 6 and 7.

266.24 Sec. 39. **[144D.066] ENFORCEMENT OF DEMENTIA CARE TRAINING**
266.25 **REQUIREMENTS.**

266.26 Subdivision 1. **Enforcement.** (a) The commissioner shall enforce the dementia care
266.27 training standards for staff working in housing with services settings and for housing
266.28 managers according to clauses (1) to (3):

266.29 (1) for dementia care training requirements in section 144D.065, the commissioner
266.30 shall review training records as part of the home care provider survey process for direct
266.31 care staff and supervisors of direct care staff, in accordance with section 144A.474. The
266.32 commissioner may also request and review training records at any time during the year;

267.1 (2) for dementia care training standards in section 144D.065, the commissioner
267.2 shall review training records for maintenance, housekeeping, and food service staff and
267.3 other staff not providing direct care working in housing with services settings as part of
267.4 the housing with services registration application and renewal application process in
267.5 accordance with section 144D.03. The commissioner may also request and review training
267.6 records at any time during the year; and

267.7 (3) for housing managers, the commissioner shall review the statement verifying
267.8 compliance with the required training described in section 144D.10, paragraph (d),
267.9 through the housing with services registration application and renewal application process
267.10 in accordance with section 144D.03. The commissioner may also request and review
267.11 training records at any time during the year.

267.12 (b) The commissioner shall specify the required forms and what constitutes sufficient
267.13 training records for the items listed in paragraph (a), clauses (1) to (3).

Subd. 2. **Fines for noncompliance.** (a) Beginning January 1, 2017, the commissioner may impose a $200 fine for every staff person required to obtain dementia care training who does not have training records to show compliance. For violations of subdivision 1, paragraph (a), clause (1), the fine will be imposed upon the home care provider, and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. For violations of subdivision 1, paragraph (a), clauses (2) and (3), the fine will be imposed on the housing with services registrant and may be appealed under the contested case procedure in section 144A.475, subdivisions 3a, 4, and 7. Prior to imposing the fine, the commissioner must allow two weeks for staff to complete the required training. Fines collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The housing with services registrant and home care provider must allow for the required training as part of employee and staff duties. Imposition of a fine by the commissioner does not negate the need for the required training. Continued noncompliance with the requirements of sections 144D.065 and 144D.10 may result in revocation or nonrenewal of the housing with services registration or home care license. The commissioner shall make public the list of all housing with services establishments that have complied with the training requirements.

Subd. 3. **Technical assistance.** From January 1, 2016, to December 31, 2016, the commissioner shall provide technical assistance instead of imposing fines for noncompliance with the training requirements. During the year of technical assistance, the commissioner shall review the training records to determine if the records meet the requirements and inform the home care provider. The commissioner shall also provide information about available training resources.

Sec. 40. Minnesota Statutes 2014, section 144E.50, is amended to read:

144E.50 EMERGENCY MEDICAL SERVICES FUND.

Subdivision 1. **Citation.** This section is the "Minnesota Emergency Medical Services System Support Act."

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

Subd. 3. ~~**Definition**~~ **Definitions.** For purposes of this section, ~~"board" means the Emergency Medical Services Regulatory Board~~ the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of health.

(b) "Grantee" means a public or private entity that receives a regional grant.

(c) "Regional emergency medical services programs" include the following regional locations:

(1) Region One, consisting of the counties of Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau;

(2) Region Two, consisting of the counties of Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, and Wilkin;

(3) Region Three, consisting of the counties of Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis;

(4) Region Four, consisting of the counties of Benton, Cass, Crow Wing, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, and Wright;

(5) Region Five, consisting of the counties of Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, and Yellow Medicine;

(6) Region Six, consisting of the counties of Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca, and Watonwan;

(7) Region Seven, consisting of the counties of Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona; and

(8) Region Eight, consisting of the counties of Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, and Washington.

(d) "Regional emergency medical services program grants" or "regional grants" means grant funds overseen and distributed according to subdivisions 4 and 5, and section 169.686, subdivision 3.

(e) "Time-sensitive syndromes" means medical conditions for which time is critical to the patient's survival and health outcome.

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Subd. 4. **Use and restrictions.** ~~Designated regional emergency medical services systems~~ (a) Grantees may use regional emergency medical services ~~system~~ program funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting ~~and improving emergency trauma and cardiac care and training~~ care of time-sensitive syndromes. No ~~part of a region's share of the fund~~ grant funds may be used to directly subsidize any ambulance service operations or rescue service operations or to purchase any vehicles or parts of vehicles for an ambulance service or a rescue service.

(b) Each grantee shall provide oversight of regional emergency medical services programs by establishing an oversight committee consisting of representatives appointed by the county board of each of the counties in the region and representatives appointed by local emergency medical services organizations.

Subd. 5. **Distribution.** ~~Money from the fund shall be distributed according to this subdivision. Ninety-five percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the board. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations. The board shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in~~ The commissioner may award up to eight regional emergency medical services program grants. The commissioner shall offer grant agreements to one applicant per region, following the review of grant applications and approval of an acceptable grant application. Grant applications must satisfactorily address the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. ~~If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the~~ Funds from the emergency medical services fund shall be distributed evenly among the ~~regions~~ grantees. If one or more of the ~~regions~~ applicants does not ~~contract~~ apply for the full amount of its even share or if its ~~proposal~~ application is unsatisfactory, then the ~~board~~ commissioner may reallocate the unused funds to the remaining ~~regions~~ grantees on a pro rata basis. ~~Five percent of the fund shall be used by the board to support regionwide reporting systems and to provide other regional administration and technical assistance.~~

~~Subd. 6. **Audits.** (a) Each regional emergency medical services board designated by the board shall be audited either annually or biennially by an independent auditor who is either a state or local government auditor or a certified public accountant who meets the independence standards specified by the General Accounting Office for audits of governmental organizations, programs, activities, and functions. The audit shall cover all funds received by the regional board, including but not limited to, funds appropriated under this section, section 144E.52, and section 169.686, subdivision 3. Expenses associated with the audit are the responsibility of the regional board.~~

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~~(b) A biennial audit specified in paragraph (a) shall be performed within 60 days following the close of the biennium. Copies of the audit and any accompanying materials shall be filed by October 1 of each odd-numbered year, beginning in 1999, with the board, the legislative auditor, and the state auditor.~~

~~(c) An annual audit specified in paragraph (a) shall be performed within 120 days following the close of the regional emergency medical services board's fiscal year. Copies of the audit and any accompanying materials shall be filed within 150 days following the close of the regional emergency medical services board's fiscal year, beginning in the year 2000, with the board, the legislative auditor, and the state auditor.~~

~~(d) If the audit is not conducted as required in paragraph (a) or copies filed as required in paragraph (b) or (c), or if the audit determines that funds were not spent in accordance with this chapter, the board shall immediately reduce funding to the regional emergency medical services board as follows:~~

~~(1) if an audit was not conducted or if an audit was conducted but copies were not provided as required, funding shall be reduced by up to 100 percent; and~~

~~(2) if an audit was conducted and copies provided, and the audit identifies expenditures made that are not in compliance with this chapter, funding shall be reduced by the amount in question plus ten percent.~~

~~A funding reduction under this paragraph is effective for the fiscal year in which the reduction is taken and the following fiscal year.~~

~~(e) The board shall distribute any funds withheld from a regional board under paragraph (d) to the remaining regional boards on a pro rata basis.~~

Sec. 41. Minnesota Statutes 2014, section 144F.01, subdivision 5, is amended to read:

Subd. 5. **Use of levy proceeds.** The proceeds of property taxes levied under this section must be used to support the providing of out-of-hospital emergency medical services including, but not limited to, first responder or rescue squads recognized by the district, ambulance services licensed under chapter 144E and recognized by the district, medical control functions set out in chapter 144E, communications equipment and systems, and programs of regional emergency medical services ~~authorized by regional boards described in section 144E.52~~.

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Sec. 14. Minnesota Statutes 2014, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

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(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form; ~~and~~

(11) the medical specialty of the physician performing the abortion;

(12) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known.

Sec. 15. **[145.417] LICENSURE OF CERTAIN FACILITIES THAT PERFORM ABORTIONS.**

Subdivision 1. **License required for facilities that perform ten or more abortions per month.** (a) A clinic, health center, or other facility in which the pregnancies of ten or more women known to be pregnant are willfully terminated or aborted each month shall be licensed by the commissioner of health and, notwithstanding Minnesota Rules, part 4675.0100, subparts 8 and 9, subject to the licensure requirements provided in Minnesota Rules, chapter 4675. The commissioner shall not require a facility licensed as a hospital or as an outpatient surgical center, pursuant to sections 144.50 to 144.56, to obtain a separate license under this section, but may subject these facilities to inspections and investigations as permitted under subdivision 2.

(b) The commissioner of health, the attorney general, an appropriate county attorney, or a woman upon whom an abortion has been performed or attempted to be performed at an unlicensed facility may seek an injunction in district court against the continued operation of the facility. Proceedings for securing an injunction may be brought by the attorney general or by the appropriate county attorney.

(c) Sanctions provided in this subdivision do not restrict other available sanctions.

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Subd. 2. **Inspections; no notice required.** No more than two times per year, the commissioner of health shall perform routine and comprehensive inspections and investigations of facilities described under subdivision 1. Every clinic, health center, or other facility described under subdivision 1, and any other premise proposed to be conducted as a facility by an applicant for a license, shall be open at all reasonable times to inspection authorized in writing by the commissioner of health. No notice need be given to any person prior to any inspection.

Subd. 3. **Licensure fee.** (a) The annual license fee for facilities required to be licensed under this section is $3,712.

(b) Fees shall be collected and deposited according to section 144.122.

Subd. 4. **Suspension, revocation, and refusal to renew.** The commissioner of health may refuse to grant or renew, or may suspend or revoke a license on any of the following grounds:

(1) violation of any of the provisions of this section or Minnesota Rules, chapter 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the facility;

(3) conduct or practices detrimental to the welfare of the patient;

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) if there is a pattern of conduct that involves one or more physicians in the facility who have a financial or economic interest in the facility, as defined in section 144.6521, subdivision 3, and who have not provided notice and disclosure of the financial or economic interest as required by section 144.6521.

Subd. 5. **Hearing.** Prior to any suspension, revocation, or refusal to renew a license, the licensee shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. At each hearing, the commissioner of health shall have the burden of establishing that a violation described in subdivision 4 has occurred. If a license is revoked, suspended, or not renewed, a new application for license may be considered by the commissioner if the conditions upon which revocation, suspension, or refusal to renew was based have been corrected and evidence of this fact has been satisfactorily furnished. A new license may be granted after proper inspection has been made and all provisions of this section and Minnesota Rules, chapter 4675, have been complied with and a recommendation for licensure has been made by the commissioner or by an inspector as an agent of the commissioner.

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Subd. 6. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Sec. 16. Minnesota Statutes 2014, section 145.423, is amended to read:

145.423 ABORTION; LIVE BIRTHS.

Subdivision 1. **Recognition; medical care.** A ~~live child born~~ born alive infant as a result of an abortion shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken by the responsible medical personnel to preserve the life and health of the ~~child~~ born alive infant.

Subd. 2. **Physician required.** When an abortion is performed after the twentieth week of pregnancy, a physician, other than the physician performing the abortion, shall be immediately accessible to take all reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, to preserve the life and health of any ~~live birth~~ born alive infant that is the result of the abortion.

Subd. 3. **Death.** If a ~~child~~ born alive infant described in subdivision 1 dies after birth, the body shall be disposed of in accordance with the provisions of section 145.1621.

Subd. 4. **Definition of born alive infant.** (a) In determining the meaning of any Minnesota statute, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of Minnesota, the words "person," "human being," "child," and "individual" shall include every infant member of the species Homo sapiens who is born alive at any stage of development.

(b) As used in this section, the term "born alive," with respect to a member of the species Homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of a natural or induced labor, cesarean section, or induced abortion.

(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species Homo sapiens at any point prior to being born alive, as defined in this section.

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Subd. 5. **Civil and disciplinary actions.** (a) Any person upon whom an abortion has been performed, or the parent or guardian of the mother if the mother is a minor, and the abortion results in the infant having been born alive, may maintain an action for death of or injury to the born alive infant against the person who performed the abortion if the death or injury was a result of simple negligence, gross negligence, wantonness, willfulness, intentional conduct, or another violation of the legal standard of care.

(b) Any responsible medical personnel that does not take all reasonable measures consistent with good medical practice to preserve the life and health of the born alive infant, as required by subdivision 1, may be subject to the suspension or revocation of that person's professional license by the professional board with authority over that person. Any person who has performed an abortion and against whom judgment has been rendered pursuant to paragraph (a) shall be subject to an automatic suspension of the person's professional license for at least one year and said license shall be reinstated only after the person's professional board requires compliance with this section by all board licensees.

(c) Nothing in this subdivision shall be construed to hold the mother of the born alive infant criminally or civilly liable for the actions of a physician, nurse, or other licensed health care provider in violation of this section to which the mother did not give her consent.

Subd. 6. **Protection of privacy in court proceedings.** In every civil action brought under this section, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

Subd. 7. **Status of born alive infant.** Unless the abortion is performed to save the life of the woman or fetus, or, unless one or both of the parents of the born alive infant agree within 30 days of the birth to accept the parental rights and responsibilities for the child, the child shall be an abandoned ward of the state and the parents shall have no parental rights or obligations as if the parental rights had been terminated pursuant to section 260C.301. The child shall be provided for pursuant to chapter 256J.

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Subd. 8. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Subd. 9. **Short title.** This act may be cited as the "Born Alive Infants Protection Act."

Sec. 17. **[145.471] PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT.**

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Prenatal Trisomy Diagnosis Awareness Act."

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

(1) "commissioner" means the commissioner of health;

(2) "deliver" means providing information to an expectant parent and, if appropriate, other family members, in a written format;

(3) "health care practitioner" means a medical professional that provides prenatal or postnatal care and administers or requests administration of a diagnostic or screening test to a pregnant woman that detects for trisomy conditions; and

(4) "trisomy conditions" means trisomy 13, otherwise known as Patau syndrome; trisomy 18, otherwise known as Edwards syndrome; and trisomy 21, otherwise known as Down syndrome.

Subd. 3. **Health care practitioner duty.** A health care practitioner who orders tests for a pregnant woman to screen for trisomy conditions shall provide the information in subdivision 4 to the pregnant woman if the test reveals a positive result for any of the trisomy conditions.

Subd. 4. **Commissioner duties.** (a) The commissioner shall make the following information available to health care practitioners:

(1) up-to-date and evidence-based information about the trisomy conditions that has been reviewed by medical experts and national trisomy organizations. The information must be provided in a written or an alternative format and must include the following:

(i) expected physical, developmental, educational, and psychosocial outcomes;

(ii) life expectancy;

(iii) the clinical course description;

(iv) expected intellectual and functional development; and

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271.16 Sec. 42. Minnesota Statutes 2014, section 145.928, is amended by adding a subdivision
271.17 to read:

271.18 Subd. 15. **Promising strategies.** For all grants awarded under this section, the
271.19 commissioner shall consider applicants that present evidence of a promising strategy to
271.20 accomplish the applicant's objective. A promising strategy shall be given the same weight
271.21 as a research or evidence-based strategy.

193.14 (v) treatment options available for the particular syndrome for which the test was
193.15 positive; and

193.16 (2) contact information for nonprofit organizations that provide information and
193.17 support services for trisomy conditions.

193.18 (b) The commissioner shall post the information in paragraph (a) on the Department
193.19 of Health Web site.

193.20 (c) The commissioner shall follow existing department practice to ensure that the
193.21 information is culturally and linguistically appropriate for all recipients.

193.22 (d) Any local or national organization that provides education or services related
193.23 to trisomy conditions may request that the commissioner include the organization's
193.24 informational material and contact information on the Department of Health Web site.
193.25 Once a request is made, the commissioner may add the information to the Web site.

193.26 **EFFECTIVE DATE.** This section is effective August 1, 2015.

193.27 Sec. 18. Minnesota Statutes 2014, section 145.928, subdivision 13, is amended to read:

193.28 Subd. 13. ~~**Report**~~ **Reports.** (a) The commissioner shall submit a biennial report
193.29 to the legislature on the local community projects, tribal government, and community
193.30 health board prevention activities funded under this section. These reports must include
193.31 information on grant recipients, activities that were conducted using grant funds,
193.32 evaluation data, and outcome measures, if available. These reports are due by January 15
193.33 of every other year, beginning in the year 2003.

193.34 (b) The commissioner shall submit an annual report to the chairs and ranking
193.35 minority members of the house of representatives and senate committees with jurisdiction
194.1 over public health on grants made under subdivision 7 to decrease racial and ethnic
194.2 disparities in infant mortality rates. The report must provide specific information on the
194.3 amount of each grant awarded to each agency or organization, the population served
194.4 by each agency or organization, outcomes of the programs funded by each grant, and
194.5 the amount of the appropriation retained by the commissioner for administrative and
194.6 associated expenses. The commissioner shall issue a report each January 15 for the
194.7 previous fiscal year beginning January 15, 2016.

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271.22 Sec. 43. Minnesota Statutes 2014, section 145A.131, subdivision 1, is amended to read:

271.23 Subdivision 1. **Funding formula for community health boards.** (a) Base funding
271.24 for each community health board eligible for a local public health grant under section
271.25 145A.03, subdivision 7, shall be determined by each community health board's fiscal year
271.26 2003 allocations, prior to unallotment, for the following grant programs: community
271.27 health services subsidy; state and federal maternal and child health special projects grants;
271.28 family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants;
271.29 and available women, infants, and children grant funds in fiscal year 2003, prior to
271.30 unallotment, distributed based on the proportion of WIC participants served in fiscal year
271.31 2003 within the CHS service area.

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

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

194.8 Sec. 19. **[145.9299] SMILE HEALTHY MINNESOTA 2016 GRANT PROGRAM.**

194.9 (a) The commissioner of health shall establish the Smile Healthy Minnesota 2016
194.10 grant program to provide access to dental care for at-risk children, adolescents, adults,
194.11 and seniors in rural areas of Minnesota. The grant is available to nonprofit agencies that
194.12 provide mobile dental care through the use of portable dental equipment. To be eligible
194.13 for a grant, a provider agency must:

194.14 (1) encourage early screening and preventative care by providing dental exams for
194.15 children one year of age;

194.16 (2) provide dental services to at-risk children, adolescents, adults, and seniors in
194.17 a health professional shortage area as defined under Code of Federal Regulations, title
194.18 42, part 5, and United States Code, title 42, section 254E, that is located outside the
194.19 seven-county metropolitan area; and

194.20 (3) provide preventative dental care including fluoride monitoring, screenings, and
194.21 minor dental treatment; and general dental care, education, and information.

194.22 (b) Grantees must report their dental health outcomes to the commissioner by
194.23 December 31, 2018.

194.24 (c) Grant recipients must be organized as a nonprofit entity in Minnesota.

194.25 (d) A grantee is prohibited from billing for preventative screenings until the
194.26 comprehensive oral health services are completed.

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

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

Sec. 44. Minnesota Statutes 2014, section 149A.20, subdivision 5, is amended to read:

Subd. 5. **Examinations.** After having met the educational requirements of subdivision 4, a person must attain a passing score on the National Board Examination administered by the Conference of Funeral Service Examining Boards of the United States, Inc. or any other examination that, in the determination of the commissioner, adequately and accurately assesses the knowledge and skills required to practice mortuary science. In addition, a person must attain a passing score on the state licensing examination administered by or on behalf of the commissioner. The state examination shall encompass the laws and rules of Minnesota that pertain to the practice of mortuary science. The commissioner shall make available copies of all pertinent laws and rules prior to administration of the state licensing examination. If a passing score is not attained on the state examination, the individual must wait two weeks before they can retake the examination.

Sec. 45. Minnesota Statutes 2014, section 149A.20, subdivision 6, is amended to read:

Subd. 6. **Internship.** (a) A person who attains a passing score on both examinations in subdivision 5 must complete a registered internship under the direct supervision of an individual currently licensed to practice mortuary science in Minnesota. Interns must file with the commissioner:

(1) the appropriate fee; and

(2) a registration form indicating the name and home address of the intern, the date the internship begins, and the name, license number, and business address of the supervising mortuary science licensee.

(b) Any changes in information provided in the registration must be immediately reported to the commissioner. The internship shall be a minimum of ~~one calendar year and a maximum of three calendar years in duration;~~ 2,080 hours to be completed within a three-year period, however, the commissioner may waive up to ~~three months~~ 520 hours of the internship time requirement upon satisfactory completion of a clinical or practicum in mortuary science administered through the program of mortuary science of the University of Minnesota or a substantially similar program approved by the commissioner. Registrations must be renewed on an annual basis if they exceed one calendar year. During the internship period, the intern must be under the direct supervision of a person holding a current license to practice mortuary science in Minnesota. An intern may be registered under only one licensee at any given time and may be directed and supervised only by the registered licensee. The registered licensee shall have only one intern registered at any given time. The commissioner shall issue to each registered intern a registration permit that must be displayed with the other establishment and practice licenses. While under the direct supervision of the licensee, the intern must ~~actively participate in the embalming of at least 25 dead human bodies and in the arrangements for and direction of at least 25 funerals~~ complete 25 case reports in each of the following areas: embalming, funeral arrangements, and services. Case reports, on forms provided by the commissioner, shall be completed by the intern~~, signed by the supervising licensee,~~ and filed with the commissioner ~~for at least 25 embalmings and funerals in which the intern participates~~ prior to the completion of the internship. Information contained in these reports that identifies the subject or the family of the subject embalmed or the subject or the family of the subject of the funeral shall be classified as licensing data under section 13.41, subdivision 2.

Sec. 46. Minnesota Statutes 2014, section 149A.40, subdivision 11, is amended to read:

Subd. 11. **Continuing education.** The commissioner ~~may~~ shall require 15 continuing education hours for renewal of a license to practice mortuary science. Nine of the hours must be in the following areas: body preparation, care, or handling, 3 CE hours; professional practices, 3 CE hours; regulation and ethics, 3 CE hours. Continuing education hours shall be reported to the commissioner every other year based on the licensee's license number. Licensees whose license ends in an odd number must report CE hours at renewal time every odd year. If a licensee's license ends in an even number, the licensee must report the licensee's CE hours at renewal time every even year.

Sec. 47. Minnesota Statutes 2014, section 149A.65, is amended to read:

149A.65 FEES.

Subdivision 1. **Generally.** This section establishes the fees for registrations, examinations, initial and renewal licenses, and late fees authorized under the provisions of this chapter.

Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

(1) ~~$50~~ $75 for the initial and renewal registration of a mortuary science intern;

(2) ~~$100~~ $125 for the mortuary science examination;

(3) ~~$125~~ $200 for issuance of initial and renewal mortuary science licenses;

(4) ~~$25~~ $100 late fee charge for a license renewal; and

(5) ~~$200~~ $250 for issuing a mortuary science license by endorsement.

Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is ~~$125~~ $200. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral establishments is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 5. **Crematories.** The initial and renewal fee for a crematory is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline hydrolysis facility is ~~$300~~ $425. The late fee charge for a license renewal is ~~$25~~ $100.

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 48. Minnesota Statutes 2014, section 149A.92, subdivision 1, is amended to read:

Subdivision 1. ~~**Exemption**~~ **Establishment update.** ~~All funeral establishments having a preparation and embalming room that has not been used for the preparation or embalming of a dead human body in the 12 calendar months prior to July 1, 1997, are exempt from the minimum requirements in subdivisions 2 to 6, except as provided in this section.~~ At the time that ownership of a funeral establishment changes, the physical location of the establishment changes, or the building housing the funeral establishment or business space of the establishment is remodeled the existing preparation and embalming room must be brought into compliance with the minimum standards in this section and in accordance with subdivision 11.

Sec. 49. Minnesota Statutes 2014, section 149A.97, subdivision 7, is amended to read:

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Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business in Minnesota that accepts funds under subdivision 2 must make a complete annual report to the commissioner. The reports may be on forms provided by the commissioner or substantially similar forms containing, at least, identification and the state of each trust account, including all transactions involving principal and accrued interest, and must be filed by March 31 of the calendar year following the reporting year along with a filing fee of $25 for each report. Fees shall be paid to the commissioner of management and budget, state of Minnesota, for deposit in the state government special revenue fund in the state treasury. Reports must be signed by an authorized representative of the funeral provider and notarized under oath. All reports to the commissioner shall be reviewed for account inaccuracies or possible violations of this section. If the commissioner has a reasonable belief to suspect that there are account irregularities or possible violations of this section, the commissioner shall report that belief, in a timely manner, to the state auditor or other state agencies as determined by the commissioner. The commissioner may require a funeral provider reporting preneed trust accounts under this section to arrange for and pay an independent third-party auditing firm to complete an audit of the preneed trust accounts every other year. The funeral provider shall report the findings of the audit to the commissioner by March 31 of the calendar year following the reporting year. This report is in addition to the annual report. The commissioner shall also file an annual letter with the state auditor disclosing whether or not any irregularities or possible violations were detected in review of the annual trust fund reports filed by the funeral providers. This letter shall be filed with the state auditor by May 31 of the calendar year following the reporting year.

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Sec. 20. Minnesota Statutes 2014, section 152.34, is amended to read:

152.34 ~~NURSING~~ HEALTH CARE FACILITIES.

~~Nursing~~ Health care facilities licensed under chapter 144A, boarding care homes licensed under section 144.50, ~~and~~ assisted living facilities, and facilities owned, controlled, managed, or under common control with hospitals licensed under chapter 144 may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility. The restrictions may include a provision that the facility will not store or maintain the patient's supply of medical cannabis, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis be used only in a place specified by the facility. Nothing contained in this section shall require the facilities to adopt such restrictions and no facility shall unreasonably limit a patient's access to or use of medical cannabis to the extent that use is authorized by the patient under sections 152.22 to 152.37.

Sec. 21. Minnesota Statutes 2014, section 157.15, subdivision 8, is amended to read:

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House Language UES1458-1

Subd. 8. **Lodging establishment.** "Lodging establishment" means: (1) a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished to the public as regular roomers, for periods of one week or more, and having five or more beds to let to the public.; or (2) a building, structure, or enclosure or any part thereof located within ten miles distance from a hospital or medical center and maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished exclusively to patients, their families, and caregivers while the patient is receiving or waiting to receive health care treatments or procedures for periods of one week or more, and where no supportive services, as defined under section 157.17, subdivision 1, paragraph (a), or health supervision services, as defined under section 157.17, subdivision 1, paragraph (b), or home care services, as defined under section 144A.471, subdivisions 6 and 7, are provided.

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

Sec. 50. Minnesota Statutes 2014, section 157.16, is amended to read:

157.16 LICENSES REQUIRED; FEES.

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts shall be issued on an annual basis. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $60 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of $120 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth camps, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of $360 shall be added to the license fee for establishments operating more than 30 days without a license.

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a $35 nonrefundable certification fee payable to the Department of Health. The commissioner shall issue a duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant submits a completed application on a form provided by the commissioner for a duplicate certificate and pays $20 to the department for the cost of duplication.

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. ~~Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7).~~ The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) Each food and beverage establishment shall pay the applicable fees specified in section 15.445.

~~(b)~~ (c) All ~~food and beverage service establishments, except special event food stands, and all~~ hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of $150, except for establishments that paid for a food and beverage establishment license under paragraph (b).

~~(c) A special event food stand shall pay a flat fee of $50 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.~~

(d) In addition to the base fee in paragraph ~~(b)~~ (c), ~~each food and beverage service establishment, other than a special event food stand and a school concession stand, and~~ each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each applicable fee category~~, additional food service, or required additional inspection~~ specified in this paragraph:

~~(1) Limited food menu selection, $60. "Limited food menu selection" means a fee category that provides one or more of the following:~~

~~(i) prepackaged food that receives heat treatment and is served in the package;~~

~~(ii) frozen pizza that is heated and served;~~

~~(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;~~

~~(iv) soft drinks, coffee, or nonalcoholic beverages; or~~

~~(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.~~

~~(2) Small establishment, including boarding establishments, $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:~~

~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;~~

~~(ii) serves dipped ice cream or soft serve frozen desserts;~~

~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~

~~(iv) is a boarding establishment; or~~

~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.~~

~~(3) Medium establishment, $310. "Medium establishment" means a fee category that meets one or more of the following:~~

~~(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;~~

~~(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or~~

~~(iii) is an establishment where food is prepared at one location and served at one or more separate locations.~~

~~Establishments meeting criteria in clause (2), item (v), are not included in this fee category.~~

~~(4) Large establishment, $540. "Large establishment" means either:~~

~~(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or~~

~~(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.~~

~~(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, $60.~~

~~(6) Beer or wine table service, $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.~~

~~(7) Alcoholic beverage service, other than beer or wine table service, $165.~~

~~"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

~~(8)~~ (1) Lodging per sleeping accommodation unit, $10, including hotels, motels, lodging establishments, and resorts, up to a maximum of $1,000. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

~~(9)~~ (2) First public pool, $325; each additional public pool, $175. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

~~(10)~~ (3) First spa, $175; each additional spa, $100. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

~~(11)~~ (4) Private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as ~~defined~~ covered in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

~~(12) Additional food service, $150. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food to the public. Additional food service does not apply to school concession stands.~~

~~(13) Additional inspection fee, $360. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.~~

(e) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

(f) A youth camp that pays fees under paragraph (b) or (d) is not required to pay fees under paragraph (e).

Subd. 3a. **Construction plan review.** ~~(e)~~ (a) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. The fee for this construction plan review is as follows:

Service Area	**Type**	**Fee**
Food	~~limited food menu~~ category 1 establishment	$275
	~~small~~ category 2 establishment	$400
	~~medium~~ category 3 establishment	$450
	~~large food~~ category 4 establishment	$500
	additional food service	$150
~~Transient food service~~ Temporary food establishment	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250

mobile food unit		$350
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~
Lodging	less than 25 rooms	$375
	25 to less than 100 rooms	$400
	100 rooms or more	$500
	less than five cabins	$350
	five to less than ten cabins	$400
	ten cabins or more	$450

~~(f)~~ (b) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	~~limited food menu~~ category 1 establishment	$250
	~~small~~ category 2 establishment	$300
	~~medium~~ category 3 establishment	$350
	~~large~~ ~~food~~ category 4 establishment	$400
	additional food service	$150
~~Transient food service~~ Temporary food establishment	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
~~Alcohol~~	~~beer or wine table service~~	~~$150~~
	~~alcohol service from bar~~	~~$250~~

Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300
	100 rooms or more	$450
	less than five cabins	$250
	five to less than ten cabins	$350
	ten cabins or more	$400

~~(g)~~ (c) Special event food stands are not required to submit construction or remodeling plans for review.

~~(h) Youth camps shall pay an annual single fee for food and lodging as follows:~~

~~(1) camps with up to 99 campers, $325;~~

~~(2) camps with 100 to 199 campers, $550; and~~

~~(3) camps with 200 or more campers, $750.~~

~~(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).~~

Subd. ~~3a.~~ 3b. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Subd. 4. **Posting requirements.** Every food and beverage service establishment, for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must have the original license posted in a conspicuous place at the establishment. ~~Mobile food units, food carts, and seasonal temporary food stands shall be issued decals with the initial license and each calendar year with license renewals. The current license year decal must be placed on the unit or stand in a location determined by the commissioner. Decals are not transferable.~~

Subd. 5. **Special revenue fund.** Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 51. Minnesota Statutes 2014, section 169.686, subdivision 3, is amended to read:

Subd. 3. **Appropriation; special account.** The fines collected for a violation of subdivision 1 must be deposited in the state treasury and credited to a special account to be known as the emergency medical services relief account. Ninety percent of the money in the account shall be ~~distributed~~ appropriated to the commissioner of health for the ~~eight~~ regional emergency medical services ~~systems designated by the Emergency Medical Services Regulatory Board under section 144E.50, for personnel education and training, equipment and vehicle purchases, and operational expenses of emergency life support transportation services~~ program grants as specified in section 144E.50, subdivision 3, for the purposes specified in section 144E.50, subdivision 4. The board of directors of each entity receiving a regional emergency medical services ~~region~~ program grant shall establish criteria for funding. Ten percent of the money in the account shall be distributed to the commissioner of public safety for the expenses of traffic safety educational programs conducted by State Patrol troopers.

Sec. 52. **WORKING GROUP ON VIOLENCE AGAINST ASIAN WOMEN AND CHILDREN.**

Subdivision 1. **Establishment.** The commissioner of health, in collaboration with the commissioners of human services and public safety, and the Council on Asian-Pacific Minnesotans, shall create a multidisciplinary working group to address violence against Asian women and children by July 1, 2015.

Subd. 2. **The working group.** The commissioner of health, in collaboration with the commissioners of human services and public safety, and the Council on Asian-Pacific Minnesotans, shall appoint 15 members representing the following groups to participate in the working group:

(1) advocates;

(2) survivors;

(3) service providers;

(4) community leaders;

(5) city and county attorneys;

(6) city officials;

(7) law enforcement; and

(8) health professionals.

At least eight of the members of the working group must be from the Asian-Pacific Islander community.

Subd. 3. **Duties.** (a) The working group must study the nature, scope, and prevalence of violence against Asian women and children in Minnesota, including domestic violence, trafficking, international abusive marriage, stalking, sexual assault, and other violence.

(b) The working group may:

(1) evaluate the adequacy and effectiveness of existing support programs;

(2) conduct a needs assessment of culturally and linguistically appropriate programs and interventions;

(3) identify barriers in delivering services to Asian women and children;

(4) identify promising prevention and intervention strategies in addressing violence against Asian women and children; and

(5) propose mechanisms to collect and monitor data on violence against Asian women and children.

Subd. 4. **Chair.** The commissioner of health shall designate one member to serve as chair of the working group.

Subd. 5. **First meeting.** The chair shall convene the first meeting by September 10, 2015.

Subd. 6. **Compensation; expense reimbursement.** Members of the working group shall be compensated and reimbursed for expenses under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 7. **Report.** By January 1, 2017, the working group must submit its recommendations and any draft legislation necessary to implement those recommendations to the commissioners of health, human services, and public safety, and the Council on Asian-Pacific Minnesotans. The Council on Asian-Pacific Minnesotans shall submit a report of findings and recommendations to the chair and ranking minority members of the committees in the house of representatives and senate having jurisdiction over health and human services and public safety by February 15, 2017.

Subd. 8. **Sunset.** The working group on violence against Asian women and children sunsets the day after the Council on Asian-Pacific Minnesotans submits the report under subdivision 7.

Senate Language S1458-2

House Language UES1458-1

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

Sec. 25. **PROHIBITION ON USE OF FUNDS.**

Subdivision 1. **Use of funds.** Funding for state-sponsored health programs shall not be used for funding abortions, except to the extent necessary for continued participation in a federal program. This subdivision applies only to state-sponsored health programs that are administered by the commissioner of human services. For purposes of this section, abortion has the meaning given in Minnesota Statutes, section 144.343, subdivision 3.

Subd. 2. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word irrespective of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Sec. 53. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall recodify Minnesota Statutes, section 144E.50, as a section in Minnesota Statutes, chapter 144, and make conforming changes consistent with the renumbering.

Sec. 54. **REPEALER.**

Minnesota Statutes 2014, section 144E.52, is repealed.