1.1 .... moves to amend H.F. No. 2402, the delete everything amendment
1.2 (A14-0926), as follows:

1.3 Page 1, delete section 1

1.4 Page 4, delete section 2

1.5 Page 5, delete section 4

1.6 Page 7, delete section 5

1.7 Page 8, delete section 6

1.8 Page 10, delete sections 8 and 9

1.9 Page 11, delete section 10

1.10 Page 12, delete sections 11 and 12

1.11 Page 13, delete sections 13 and 14

1.12 Page 14, delete sections 15 and 16

1.13 Page 15, delete section 17

1.14 Page 16, delete section 18

1.15 Page 19, delete section 21, and insert:

1.16 "Sec. 21. Minnesota Statutes 2012, section 260C.215, is amended by adding a
1.17 subdivision to read:
1.18 Subd. 9. **Preventing exposure to secondhand smoke for children in foster care.**
1.19 (a) A child in foster care shall not be exposed to any type of secondhand smoke in the
1.20 following settings:
1.21 (1) a licensed foster home or any enclosed space connected to the home, including a
1.22 garage, porch, deck, or similar space; or
1.23 (2) a motor vehicle while a foster child is transported.
1.24 (b) Smoking in outdoor areas on the premises of the home is permitted, except when
1.25 a foster child is present and exposed to secondhand smoke.
1.26 (c) The home study required in subdivision 4, clause (5), must include a plan to
1.27 maintain a smoke-free environment for foster children.

2.1 (d) If a foster parent fails to provide a smoke-free environment for a foster child, the
2.2 child-placing agency must ask the foster parent to comply with a plan that includes training
2.3 on the health risks of exposure to secondhand smoke. If the agency determines that the
2.4 foster parent is unable to provide a smoke-free environment and that the home environment
2.5 constitutes a health risk to a foster child, the agency must reassess whether the placement
2.6 is based on the child's best interests consistent with section 260C.212, subdivision 2.
2.7 (e) Nothing in this subdivision shall delay the placement of a child with a relative,
2.8 consistent with section 245A.035, unless the relative is unable to provide for the
2.9 immediate health needs of the individual child.
2.10 (f) If a child's best interests would most effectively be served by placement in a home
2.11 which will not meet the requirements of paragraph (a), the failure to meet the requirements
2.12 of paragraph (a) shall not be a cause to deny placement in that home.
2.13 (g) Nothing in this subdivision shall be interpreted to interfere, conflict with, or be a
2.14 basis for denying placement pursuant to the provisions of the federal Indian Child Welfare
2.15 Act or Minnesota Indian Family Preservation Act.
2.16 (h) Nothing in this subdivision shall be interpreted to interfere with traditional or
2.17 spiritual Native American or religious ceremonies involving the use of tobacco."
2.18 Pages 25 to 29, delete sections 4 to 8 and insert:

2.19 "Sec. 4. **[151.71] MAXIMUM ALLOWABLE COST PRICING.**
2.20 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms
2.21 have the meanings given.
2.22 (b) "Health plan company" has the meaning provided in section 62Q.01, subdivision
2.23 4.
2.24 (c) "Pharmacy benefit manager" means an entity doing business in this state that
2.25 contracts to administer or manage prescription drug benefits on behalf of any health plan
2.26 company that provides prescription drug benefits to residents of this state.
2.27 Subd. 2. **Pharmacy benefit manager contracts with pharmacies; maximum**
2.28 **allowable cost pricing.** (a) In each contract between a pharmacy benefit manager and
2.29 a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit
2.30 manager a current list of the sources used to determine maximum allowable cost pricing.
2.31 The pharmacy benefit manager shall update the pricing information at least every seven
2.32 business days and provide a means by which contracted pharmacies may promptly review
2.33 current prices in an electronic, print, or telephonic format within one business day at no
2.34 cost to the pharmacy. A pharmacy benefit manager shall maintain a procedure to eliminate
2.35 products from the list of drugs subject to maximum allowable cost pricing in a timely
2.36 manner in order to remain consistent with changes in the marketplace.

3.1 (b) In order to place a prescription drug on a maximum allowable cost list, a
3.2 pharmacy benefit manager shall ensure that the drug is generally available for purchase by
3.3 pharmacies in this state from a national or regional wholesaler and is not obsolete.
3.4 (c) Each contract between a pharmacy benefit manager and a pharmacy must include
3.5 a process to appeal, investigate, and resolve disputes regarding maximum allowable cost
3.6 pricing that includes:
3.7 (1) a 15 business day limit on the right to appeal following the initial claim;
3.8 (2) a requirement that the appeal be investigated and resolved within seven business
3.9 days after the appeal; and
3.10 (3) a requirement that a pharmacy benefit manager provide a reason for any appeal
3.11 denial and identify the national drug code of a drug that may be purchased by the
3.12 pharmacy at a price at or below the maximum allowable cost price as determined by
3.13 the pharmacy benefit manager.
3.14 (d) If the appeal is upheld, the pharmacy benefit manager shall make an adjustment
3.15 to the maximum allowable cost price no later than one business day after the date of
3.16 determination. The pharmacy benefit manager shall make the price adjustment applicable
3.17 to all similarly situated network pharmacy providers as defined by the plan sponsor.

3.18 **EFFECTIVE DATE.** This section is effective January 1, 2015."
3.19 Page 34, delete lines 35 and 36
3.20 Page 35, delete lines 1 and 2
3.21 Page 35, line 3, strike "(h)" and insert "(g)"
3.22 Page 35, delete lines 19 to 21
3.23 Page 37, delete section 11 and insert:

3.24 "Sec. 11. **[604A.05] GOOD SAMARITAN OVERDOSE MEDICAL**
3.25 **ASSISTANCE.**
3.26 Subdivision 1. **Person seeking medical assistance; immunity from prosecution.**
3.27 A person acting in good faith who seeks medical assistance for another person who is
3.28 experiencing a drug overdose may not be arrested, charged, prosecuted, or penalized, or
3.29 have that person's property subject to civil forfeiture for the possession, sharing, or use
3.30 of a controlled substance or drug paraphernalia; or a violation of a condition of pretrial
3.31 release, probation, furlough, supervised release, or parole. A person qualifies for the
3.32 immunities provided in this subdivision only if: (1) the evidence for the arrest, charge,
3.33 prosecution, seizure, or penalty was obtained as a result of the person's seeking medical
3.34 assistance for another person; and (2) the person seeks medical assistance for another
3.35 person who is in need of medical assistance for an immediate health or safety concern,

4.1 provided that the person who seeks the medical assistance is the first person to seek the
4.2 assistance, provides the person's name and contact information, remains on the scene until
4.3 assistance arrives and is provided, and cooperates with the authorities.

4.4 Subd. 2. **Person experiencing an overdose; immunity from prosecution.** A
4.5 person who experiences a drug overdose and is in need of medical assistance may not be
4.6 arrested, charged, prosecuted, or penalized, or have that person's property subject to civil
4.7 forfeiture for: (1) the possession of a controlled substance or drug paraphernalia; or (2)
4.8 a violation of a condition of pretrial release, probation, furlough, supervised release, or
4.9 parole. A person qualifies for the immunities provided in this subdivision only if the
4.10 evidence for the arrest, charge, prosecution, seizure, or penalty was obtained as a result
4.11 of the drug overdose and the need for medical assistance.

4.12 Subd. 3. **Effect on other criminal prosecutions.** (a) The immunity provisions of
4.13 this section do not preclude prosecution of the person on the basis of evidence obtained
4.14 from an independent source.

4.15 (b) The act of providing first aid or other medical assistance to someone who is
4.16 experiencing a drug overdose may be used as a mitigating factor in a criminal prosecution
4.17 for which immunity is not provided.

4.18 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
4.19 actions arising from incidents occurring on or after that date."

4.20 Page 37, line 12, after the period, insert "This subdivision does not apply if the
4.21 licensed health care professional is acting during the course of regular employment and
4.22 receiving compensation or expecting to receive compensation for those actions."

4.23 Page 40, line 34, delete the new language

4.24 Page 40, line 35, delete the new language and reinstate "expires June 30," and
4.25 insert "2018"

4.26 Page 41, line 10, delete the new language

4.27 Page 41, line 11, delete the new language and reinstate "expires June 30," and
4.28 insert "2018"

4.29 Page 43, line 17, delete the new language and reinstate "expires June 30," and
4.30 insert "2018"

4.31 Page 68, line 12, delete "or the commissioner of health"

4.32 Page 68, lines 14 and 22, delete "or commissioner"

4.33 Page 70, delete section 45 and insert:

4.34 "Sec. 45. Minnesota Statutes 2012, section 214.32, is amended to read:

4.35 **214.32 PROGRAM OPERATIONS AND RESPONSIBILITIES.**

Subdivision 1. **Management.** (a) A Health Professionals Services Program Committee is established, consisting of ~~one person appointed by each participating board, with each participating board having one vote.~~ no fewer than three, or more than six, executive directors of health-related licensing boards or their designees, and two members of the advisory committee established in paragraph (d). Program committee members from the health-related licensing boards shall be appointed by a means agreeable to the executive directors of the health-related licensing boards in July of odd-numbered years. Members from the advisory committee shall be appointed by a means agreeable to advisory committee members in July of odd-numbered years. The program committee shall designate one board to provide administrative management of the program, set the program budget and the pro rata share of program expenses to be borne by each participating board, provide guidance on the general operation of the program, including hiring of program personnel, and ensure that the program's direction is in accord with its authority. The program committee shall establish uniform criteria and procedures governing termination and discharge for all health professionals served by the health professionals services program. If the participating boards change which board is designated to provide administrative management of the program, any appropriation remaining for the program shall transfer to the newly designated board on the effective date of the change. The participating boards must inform the appropriate legislative committees and the commissioner of management and budget of any change in the administrative management of the program, and the amount of any appropriation transferred under this provision.

(b) The designated board, upon recommendation of the Health Professional Services Program Committee, shall hire the program manager and employees and pay expenses of the program from funds appropriated for that purpose. The designated board may apply for grants to pay program expenses and may enter into contracts on behalf of the program to carry out the purposes of the program. The participating boards shall enter into written agreements with the designated board.

(c) An advisory committee is established ~~to advise the program committee~~ consisting of:

(1) one member appointed by each ~~of the following: the Minnesota Academy of Physician Assistants, the Minnesota Dental Association, the Minnesota Chiropractic Association, the Minnesota Licensed Practical Nurse Association, the Minnesota Medical Association, the Minnesota Nurses Association, and the Minnesota Podiatric Medicine Association~~ of the professional associations whose members are eligible for health professionals services program services; and

6.1 (2) ~~one member appointed by each of the professional associations of the other~~
6.2 ~~professions regulated by a participating board not specified in clause (1); and~~
6.3 ~~(3)~~ two public members, as defined by section 214.02.
6.4 (d) Members of the advisory committee shall be appointed for two years and
6.5 members may be reappointed.
6.6 (f) The advisory committee shall:
6.7 (1) provide advice and consultation to the health professionals services program staff;
6.8 (2) serve as a liaison to all regulated health professionals who are eligible to
6.9 participate in the health professionals services program; and
6.10 (3) provide advice and recommendations to the program committee.
6.11 Subd. 2. **Services.** (a) The program shall provide the following services to program
6.12 participants:
6.13 (1) referral of eligible regulated persons to qualified professionals for evaluation,
6.14 treatment, and a written plan for continuing care consistent with the regulated person's
6.15 illness. The referral shall take into consideration the regulated person's financial resources
6.16 as well as specific needs;
6.17 (2) development of individualized program participation agreements between
6.18 participants and the program to meet the needs of participants and protect the public. An
6.19 agreement may include, but need not be limited to, recommendations from the continuing
6.20 care plan, practice monitoring, health monitoring, practice restrictions, random drug
6.21 screening, support group participation, filing of reports necessary to document compliance,
6.22 and terms for successful completion of the regulated person's program; and
6.23 (3) monitoring of compliance by participants with individualized program
6.24 participation agreements or board orders.
6.25 (b) The program may develop services related to sections 214.31 to 214.37 for
6.26 employers and colleagues of regulated persons from participating boards.
6.27 Subd. 3. **Participant costs.** Each program participant shall be responsible for
6.28 paying for the costs of physical, psychosocial, or other related evaluation, treatment,
6.29 laboratory monitoring, and random drug screens.
6.30 Subd. 4. **Eligibility.** Admission to the health professional services program is
6.31 available to a person regulated by a participating board who is unable to practice with
6.32 reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or
6.33 any other materials, or as a result of any mental, physical, or psychological condition.
6.34 Admission in the health professional services program shall be denied to persons:
6.35 (1) who have diverted controlled substances for other than self-administration;

7.1 (2) who have been terminated from this or any other state professional services
7.2 program for noncompliance in the program, unless referred by a participating board or the
7.3 commissioner of health;
7.4 (3) currently under a board disciplinary order or corrective action agreement, unless
7.5 referred by a board;
7.6 (4) ~~regulated under sections 214.17 to 214.25, unless referred by a board or by the~~
7.7 ~~commissioner of health;~~
7.8 ~~(5)~~ accused of sexual misconduct; or
7.9 ~~(6)~~ (5) whose continued practice would create a serious risk of harm to the public.
7.10 Subd. 5. **Completion; voluntary termination; discharge.** (a) A regulated person
7.11 completes the program when the terms of the program participation agreement are fulfilled.
7.12 (b) A regulated person may voluntarily terminate participation in the health
7.13 professionals service program at any time ~~by reporting to the person's board~~ which shall
7.14 result in the program manager making a report to the regulated person's board under
7.15 section 214.33, subdivision 3.
7.16 (c) The program manager may choose to discharge a regulated person from the
7.17 program and make a referral to the person's board at any time for reasons including but not
7.18 limited to: the degree of cooperation and compliance by the regulated person, the inability
7.19 to secure information or the medical records of the regulated person, or indication of other
7.20 possible violations of the regulated person's practice act. The regulated person shall be
7.21 notified in writing by the program manager of any change in the person's program status.
7.22 A regulated person who has been terminated or discharged from the program may be
7.23 referred back to the program for monitoring.
7.24 Subd. 6. **Duties of a health related licensing board.** (a) Upon receiving notice from
7.25 the program manager that a regulated person has been discharged due to noncompliance
7.26 or voluntary withdrawal, when the appropriate licensing board has probable cause to
7.27 believe continued practice by the regulated person presents an imminent risk of harm, the
7.28 licensing board shall temporarily suspend the regulated person's professional license. The
7.29 suspension shall take effect upon written notice to the regulated person and shall specify
7.30 the reason for the suspension.
7.31 (b) The suspension shall remain in effect until the appropriate licensing board
7.32 completes an investigation and issues a final order in the matter after a hearing.
7.33 (c) At the time it issues the suspension notice, the appropriate licensing board shall
7.34 schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act.
7.35 The regulated person shall be provided with at least 20 days' notice of any hearing held

8.1 pursuant to this subdivision. The hearing shall be scheduled to being no later than 60
8.2 days after issuance of the suspension order.
8.3 (d) This subdivision does not apply to the Office of Complementary and Alternative
8.4 Health Care Programs."
8.5 Page 80, line 7, delete everything after "drugs"
8.6 Page 80, delete lines 8 to 10
8.7 Page 80, line 11, delete everything before the semicolon
8.8 Page 94, line 32, delete everything after the period
8.9 Page 94, delete line 33
8.10 Page 96, delete lines 29 to 36
8.11 Page 97, delete lines 1 to 6
8.12 Page 99, line 17, delete everything before "Any"
8.13 Page 99, line 21, delete "as defined in" and insert "pursuant to"
8.14 Page 99, delete lines 22 to 31
8.15 Page 125, delete section 21
8.16 Page 139, delete section 21 and insert:

8.17 "Sec. 21. Minnesota Statutes 2012, section 144D.065, is amended to read:

8.18 **144D.065 TRAINING IN DEMENTIA CARE REQUIRED.**

8.19 (a) If a housing with services establishment registered under this chapter has a
8.20 special program or special care unit for residents with Alzheimer's disease or other
8.21 dementias or advertises, markets, or otherwise promotes the establishment as providing
8.22 services for persons with Alzheimer's disease or ~~related disorders~~ other dementias, whether
8.23 in a segregated or general unit, ~~the establishment's direct care staff and their supervisors~~
8.24 ~~must be trained in dementia care~~ employees of the establishment and of the establishment's
8.25 arranged home care provider must meet the following training requirements:
8.26 (1) supervisors of direct-care staff must have at least eight hours of initial training on
8.27 topics specified under paragraph (b) within 120 working hours of the employment start
8.28 date, and must have at least two hours of training on topics related to dementia care for
8.29 each 12 months of employment thereafter;
8.30 (2) direct-care employees must have completed at least eight hours of initial training
8.31 on topics specified under paragraph (b) within 160 working hours of the employment start
8.32 date. Until this initial training is complete, an employee must not provide direct care unless
8.33 there is another employee on site who has completed the initial eight hours of training on
8.34 topics related to dementia care and who can act as a resource and assist if issues arise. A
8.35 trainer of the requirements under paragraph (b), or a supervisor meeting the requirements
8.36 in paragraph (a), clause (1), must be available for consultation with the new employee until

9.1 the training requirement is complete. Direct-care employees must have at least two hours
9.2 of training on topics related to dementia for each 12 months of employment thereafter;
9.3 (3) staff who do not provide direct care, including maintenance, housekeeping
9.4 and food service staff must have at least four hours of initial training on topics specified
9.5 under paragraph (b) within 160 working hours of the employment start date, and must
9.6 have at least two hours of training on topics related to dementia care for each 12 months of
9.7 employment thereafter; and
9.8 (4) new employees may satisfy the initial training requirements by producing written
9.9 proof of previously completed required training within the past 18 months.
9.10 (b) Areas of required training include:
9.11 (1) an explanation of Alzheimer's disease and related disorders;
9.12 (2) assistance with activities of daily living;
9.13 (3) problem solving with challenging behaviors; and
9.14 (4) communication skills.
9.15 (c) The establishment shall provide to consumers in written or electronic form a
9.16 description of the training program, the categories of employees trained, the frequency
9.17 of training, and the basic topics covered. This information satisfies the disclosure
9.18 requirements of section 325F.72, subdivision 2, clause (4).
9.19 (d) Housing with services establishments not included in paragraph (a) that provide
9.20 assisted living services under chapter 144G must meet the following training requirements:
9.21 (1) supervisors of direct-care staff must have at least four hours of initial training on
9.22 topics specified under paragraph (b) within 120 working hours of the employment start
9.23 date, and must have at least two hours of training on topics related to dementia care for
9.24 each 12 months of employment thereafter;
9.25 (2) direct-care employees must have completed at least four hours of initial training
9.26 on topics specified under paragraph (b) within 160 working hours of the employment
9.27 start date. Until this initial training is complete, an employee must not provide direct
9.28 care unless there is another employee on site who has completed the initial four hours of
9.29 training on topics related to dementia care and who can act as a resource and assist if
9.30 issues arise. A trainer of the requirements under section 144D.065, paragraph (b), or
9.31 supervisor meeting the requirements under section 144D.065, paragraph (a), clause (1),
9.32 must be available for consultation with the new employee until the training requirement is
9.33 complete. Direct-care employees must have at least two hours of training on topics related
9.34 to dementia for each 12 months of employment thereafter;
9.35 (3) staff who do not provide direct care, including maintenance, housekeeping
9.36 and food service staff must have at least four hours of initial training on topics specified

10.1 under paragraph (b) within 160 working hours of the employment start date, and must
10.2 have at least two hours of training on topics related to dementia care for each 12 months of
10.3 employment thereafter; and
10.4 (4) new employees may satisfy the initial training requirements by producing written
10.5 proof of previously completed required training within the past 18 months.

10.6 **EFFECTIVE DATE.** This section is effective January 1, 2016."
10.7 Page 140, delete section 22 and insert:

10.8 "Sec. 22. **[144D.10] MANAGER REQUIREMENTS.**
10.9 (a) The person primarily responsible for oversight and management of a housing
10.10 with services establishment, as designated by the owner of the housing with services
10.11 establishment, must obtain at least 30 hours of continuing education every two years of
10.12 employment as the manager in topics relevant to the operations of the housing with services
10.13 establishment and the needs of its tenants. Continuing education earned to maintain a
10.14 professional license, such as nursing home administrator license, nursing license, social
10.15 worker license, and real estate license, can be used to complete this requirement.
10.16 (b) For managers of establishments identified in section 325F.72, this continuing
10.17 education must include at least eight hours of documented training on the topics identified
10.18 in section 144D.065, subdivision1, paragraph (b), within 160 working hours of hire, and
10.19 two hours of training these topics for each 12 months of employment thereafter.
10.20 (c) For managers of establishments not covered by section 325F.72, but who provide
10.21 assisted living services under chapter 144G, this continuing education must include at
10.22 least four hours of documented training on the topics identified in section 144D.065,
10.23 subdivision 1, paragraph (b), within 160 working hours of hire, and two hours of training
10.24 on these topics for each 12 months of employment thereafter.
10.25 (d) A statement verifying compliance with the continuing education requirement
10.26 must be included in the housing with services establishment's annual registration to the
10.27 commissioner of health. The establishment must maintain records for at least three years
10.28 demonstrating that the person primarily responsible for oversight and management of the
10.29 establishment has attended educational programs as required by this section.
10.30 (e) New managers may satisfy the initial dementia training requirements by producing
10.31 written proof of previously completed required training within the past 18 months.
10.32 (f) This section does not apply to an establishment registered under section
10.33 144D.025 serving the homeless.

10.34 **EFFECTIVE DATE.** This section is effective January 1, 2016."
10.35 Page 141, delete section 23 and insert:

11.1 "Sec. 23. **[144D.11] EMERGENCY PLANNING.**

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

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

11.7 (2) post an emergency disaster plan prominently;

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

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

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

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

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

11.17 **EFFECTIVE DATE.** This section is effective January 1, 2016."

11.18 Page 151, delete section 36 and insert:

11.19 "Sec. 36. **EVALUATION AND REPORTING REQUIREMENTS.**

11.20 (a) The commissioner of health shall consult with the Alzheimer's Association,
11.21 Aging Services of Minnesota, Care Providers of Minnesota, the ombudsman for long-term
11.22 care, Minnesota Home Care Association, and other stakeholders to evaluate the following:

11.23 (1) whether additional settings, provider types, licensed and unlicensed personnel, or
11.24 health care services regulated by the commissioner should be required to comply with the
11.25 training requirements in Minnesota Statutes, sections 144D.065, 144D.10, and 144D.11;

11.26 (2) cost implications for the groups or individuals identified in clause (1) to comply
11.27 with the training requirements;

11.28 (3) dementia education options available;

11.29 (4) existing dementia training mandates under federal and state statutes and rules; and

11.30 (5) the enforceability of Minnesota Statutes, sections 144D.065, 144D.10, and
11.31 144D.11, and methods to determine compliance with the training requirements.

11.32 (b) The commissioner shall report the evaluation to the chairs of the health and
11.33 human services committees of the legislature no later than February 15, 2015, along with
11.34 any recommendations for legislative changes."

11.35 Renumber the sections in sequence and correct the internal references

12.1 Amend the title accordingly