Minnesota Medical Group Management Association

2014 Session
Minnesota Legislative Report

Prepared by
Nancy Haas
James Clark
Julian Plamann

MESSERLI & KRAMER

525 Park Street, Suite 130
Saint Paul, Minnesota 55103
651-228-9757

Table of Contents

2014 LEGISLATIVE SESSION SUMMARY

Prior to the commencement of the 2014 Legislative Session, it was clear that lawmakers were preparing for a fast pace. With hopes of ending before the Constitutional deadline of May 19, the Legislature set early deadlines for committees to complete their work. However, it took more than 80 days and some late nights for the major issues confronting Minnesota to be hashed out. After a flurry of last-minute negotiations, the Legislature adjourned Sine Die Friday, May 16.

Historically, even-numbered years at the Legislature are non-budget, capital bonding years. However, shortly after session began, Minnesota Management and Budget announced a projected budget surplus in the current biennium. This brought about a unique opportunity to distribute more than $1.23 billion.

In early-March, after the positive forecast was announced, the Governor released a plan proposing $616 million in tax cuts and an increase in the current budget reserve by $455 million. Following suit, the House released a tax bill totaling a little more than $500 million, which proposed to conform the state's tax code and repeal unpopular business-to-business taxes. Following negotiations between the Legislature and Governor, the Senate released a plan that would provide $450 million in tax cuts as well as federal conformity to Minnesota taxpayers. This proposal was passed and signed into law on March 21, 2014.

By late-March, the Legislature began working on a supplemental appropriations bill to spend a portion of the state's $1.2 billion surplus and a second omnibus tax bill to provide a number of tax cuts, including property tax reductions for homeowners, renters and farmers. Legislators also began working on some major policy items, including medical cannabis, the Women's Economic Security Act and minimum wage.

The final week of session moved very quickly. In a marathon two days, the Legislature passed the second Omnibus Tax Bill, the Supplemental Budget Bill, two Capital Investment Bills (one general-obligation bonds and one cash), the Medical Cannabis bill and several other policy proposals. The following is a brief overview of what was included in these measures:

Taxes

As part of the session ending agreement, the Legislature passed an additional $103 million in tax reductions on the last day of the session. The second Tax Bill provides property tax relief for homeowners, renters and farmers; targeted income and sales tax relief; local development modifications and funding; and LGA increases. It passed with broad bipartisan support.

Supplemental Budget

After over a month of negotiations, House and Senate budget conferees reached an agreement on a $283 million supplemental budget. The compromise bill provides the following increases to the budgets adopted in 2013:

- Health & Human Services $103.9 million
- Education $54 million
- Public Safety $35 million
- Higher Education $22.25 million
- Jobs & Economic Development $19.8 million
- Transportation $15 million
- Environment & Agriculture $12 million
- State Government & Veterans Affairs $705,000
- Other bills with spending $20 million

Capital Investment
The Legislature reached an agreement on a pair of bi-partisan capital investment bills which spent over $1 billion on infrastructure projects across the state. These bills spend $846 million in general-obligation bonds and $198.7 million from the state's budget surplus for these projects.

Medical Cannabis
In the final days of session, House and Senate Conferees, Governor Dayton and stakeholders were able to reach an agreement on a proposal to allow for the use of medical cannabis. The legislation, among the strictest in the country, creates a Patient Registry System to allow for the purchase and use of the treatment. Patients will be charged a registration fee of $50-$200 and must meet the list of qualified medical conditions. The bill requires two manufacturers and a total of eight distribution sites in Minnesota.It also allows the Minnesota Department of Health to conduct an observational study on the impacts of use and gives them the ability to add additional medical conditions at a later time. It may not be smoked, or used in plant or leaf form.

The Women's Economic Security Act (WESA)
This legislation contained a number of provisions directed towards female employees in the workplace. It takes steps to close the gender pay gap, providing ways to bring women into higher wage, higher-impact careers, or jobs that are dubbed "traditionally male."

Minimum Wage
Minnesota's minimum wage will rise from one of the lowest wages in the country — $6.15 — to one of the highest wages. The increases are phased in, with the first increase coming this August, when the minimum climbs to $8.00. In August 2015 it will rise to $8.50, then $9.50 by August 2016. Increases after that will be linked to inflation.

E-Cigarettes
The Legislature adopted a proposal which implements new restrictions to e-cigarettes and vaping products. The bill imposes restrictions on packaging, regulates sales and limits the use in schools, hospitals, publicly owned buildings and nursing homes.

With the Legislature adjourned, the focus will now turn to upcoming elections. Both the Governor and members of the House of Representatives are up for election this year. After two years of a DFL controlled state government, legislators must gear up for an unpredictable election fight to hold onto their jobs at the Capitol.

Sincerely,

The Government Affairs Team
Messerli & Kramer, P.A.

HEALTH & HUMAN SERVICES

SUPPLEMENTAL BUDGET BILL

H.F. 3172 – Chapter 312
Representative Lyndon Carlson & Senator Chuck Wiger
Effective Various Dates

After over a month of negotiations, House and Senate budget conferees reached an agreement on a $283 million supplemental budget. The compromise bill provides a total increase of $103.9 million for Health and Human Services.

Below are provisions of interest contained in the bill:

Health Care Homes Advisory Committee

Sec. 36. Minnesota Statutes 2012, section 256B.0751, is amended by adding a subdivision to read:

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

(b) The commissioners shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; mental health providers; nursing and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes. The commissioners, in making appointments to the committee, shall ensure geographic representation of all regions of the state.

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

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

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

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

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

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

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

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

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

Legislative Health Care Workforce

*Sec. 9. **LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION.***

*Subdivision 1. **Legislative oversight.** The Legislative Health Care Workforce Commission is created to study and make recommendations to the legislature on how to achieve the goal of strengthening the workforce in health care.*

*Subd. 2. **Membership.** The Legislative Health Care Workforce Commission consists of five members of the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration and five members of the house of representatives appointed by the speaker of the house. The Legislative Health Care Workforce Commission must include three members of the majority party and two members of the minority party in each house.*

*Subd. 3. **Officers.** The commission must elect a chair and may elect other officers as it determines are necessary. The chair shall alternate between a member of the senate and a member of the house of representatives in January of each odd-numbered year.*

*Subd. 4. **Initial appointments and meeting.** Appointing authorities for the Legislative Health Care Workforce Commission must make initial appointments by June 1, 2014. The speaker of the house of representatives must designate one member of the commission to convene the first meeting of the commission by June 15, 2014.*

*Subd. 5. **Report to the legislature.** The Legislative Health Care Workforce Commission must provide a preliminary report making recommendations to the legislature by December 31, 2014. The commissioner must provide a final report to the legislature by December 31, 2016. The final report must:*

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;

(ii) disparities in income between primary care and other providers; and

(iii) negative perceptions of primary care among students.

*Subd. 6. **Assistance to the commission.** The commissioners of health, human services, commerce, and other state agencies shall provide assistance and technical support to the commission at the request of the commission. The Minnesota Medical Association and other stakeholder groups shall also provide advice to the commission as needed. The commission may convene subcommittees to provide additional assistance and advice to the commission.*

*Subd. 7. **Commission member expenses.** Members of the commission may receive per diem and expense reimbursement from money appropriated for the commission in the manner and amount prescribed for per diem and expense payments by the senate Committee on Rules and Administration and the House Committee on Rules and Legislative Administration.*

*Subd. 8. **Expiration.** The Legislative Health Care Workforce Commission expires on January 1, 2017.*

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

Quality Transparency

*Sec. 10. **QUALITY TRANSPARENCY.***

(a) The commissioner of health shall develop an implementation plan for stratifying measures based on disability, race, ethnicity, language, and other sociodemographic factors that are correlated with health disparities and impact performance on quality measures. The plan must be designed so that quality measures can be stratified beginning January 1, 2017, in order to advance work aimed at identifying and eliminating health disparities. By January 15, 2015, the commissioner shall submit a report to the chairs

and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction on health and human services and finance with the plan, including an estimated budget, timeline, and processes to be used for implementation.
(b) The commissioner of health shall assess the risk adjustment methodology established under Minnesota Statutes, section 62U.02, subdivision 3, for the potential for harm and unintended consequences for patient populations who experience health disparities, and the providers who serve them, and identify changes that may be needed to alleviate harm and unintended consequences. By January 15, 2016, the commissioner shall submit a report to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction on health and human services and finance with the result of the assessment of the risk-adjustment methodology and any recommended changes.
(c) The commissioner shall develop the plan described in paragraph (a), in consultation with consumer, community and advocacy organizations representing diverse communities; health plan companies; providers; quality measurement organizations; and safety net providers that primarily serve communities and patient populations with health disparities. The commissioner shall use culturally appropriate methods of consultation and engagement with consumer and advocacy organizations led by and representing diverse communities by race, ethnicity, language, and sociodemographic factors.

Data on Chronic Pain Therapies

Sec. 11. ***DATA ON CHRONIC PAIN THERAPIES.***
(a) The commissioner of health shall gather the following data on the provision of chronic pain treatment procedures by physicians, doctors of osteopathy, and certified registered nurse anesthetists who perform these procedures:
(1) the types and number of chronic pain management procedures performed within the last 36 months;
(2) the types of health professionals who perform chronic pain treatment procedures and the professional licenses they hold; and
(3) the location and type of facility in which the chronic pain treatment procedures are performed.
(b) The commissioner shall submit a report with the compiled data to the chairs and ranking minority members of the house and senate committees with jurisdiction over health and human services finance and policy by January 15, 2015.
(c) The commissioner of health may use the data submitted under Minnesota Statutes, section 62U.04, subdivision 4, paragraph (a), to carry out the requirements of this section.

Sec. 4. ***BOARD OF NURSING.***	***$***	***-0-***	***$***	***75,000***

Chronic pain therapies. *$75,000 in fiscal year 2015 from the state government special revenue fund is transferred to the commissioner of health to gather data and complete a report on the provision of chronic pain therapies by physicians, doctors of osteopathy, and certified registered nurse anesthetists.*

Separate Billing by CRNAs

Sec. 20. Minnesota Statutes 2012, section 256.969, subdivision 10, is amended to read:
Subd. 10. ***Separate billing by certified registered nurse anesthetists.*** *Hospitals ~~may~~ must exclude certified registered nurse anesthetist costs from the operating payment rate ~~as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of even-numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree~~*

~~*that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services.*~~
~~*For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.*~~

Reimbursement for Basic Care Services

Sec. 40. Minnesota Statutes 2013 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and
related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, ~~*medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics,*~~ *hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based*
purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates in effect on June 30, 2014.

~~*(f)*~~ *(g) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.*

OMNIBUS HEALTH & HUMAN SERVICES POLICY BILL

H.F. 2402 – Chapter 291
Representative Tina Liebling & Senator Kathy Sheran
Effective Various Dates

This bill made a number of changes aimed at protecting health by reforming the local public health system, updating licensing statutes for numerous health professionals, and putting safeguards in place for children's health.

The bill passed the House on a vote of 93-35 and passed the Senate on a vote of 52-13. Governor Dayton signed the bill into law on May 19th. Below is a brief summary of some key provisions:

Board of Pharmacy Changes

Opiate Use/Abuse – Article 2

Included in the language are updates to the Prescription Monitoring Program. It requires reporting for schedule V controlled substances, and classifies tramadol and butalbital as controlled substances for the purposes of the program and adds veterinarians to the definition of prescriber. It exempts dispensers from reporting controlled substance prescriptions for persons residing in a health care facility when the drug is distributed through the use of an automated drug distribution system. It also exempts individuals receiving drug samples, clarifies the existing requirement that patients be given conspicuous notice of the reporting requirements, and requires notice to be given that the information may be used for program administration.

The bill requires data reported to be available to permissible users for 12 months (current law requires the data to be retained for 12 months and then removed from the database) except that certain staff may use all data collected under the program to administer, operate, and maintain the program and conduct trend analysis and other studies. However, it requires data retained beyond 24 months to be de-identified.

The bill also includes a study done by the Board of Pharmacy in collaboration with the Prescription Monitoring Program Advisory Task Force. The study will analyze the impact of the prescription drug monitoring program on rates of chemical abuse and prescription drug abuse. It will also be required to report back to the legislature with recommendations on whether or not to require the use of the prescription monitoring program database by prescribers when prescribing, and pharmacists when dispensing, a controlled substance. They will also give recommendations on approaches to encourage access to appropriate treatment for prescription abuse.

Compounding – Article 5, Section 1

This legislation also creates a new definitions for "compounding," "anticipatory compounding," extemporaneous compounding," and "compounded positron emission tomography drug."

"Compounding" is defined as the preparation, mixing, assembling, packaging, and labeling of a drug for a specific patient pursuant to a prescription drug order. This term includes anticipatory compounding and preparation of drugs in which all bulk drug substances and components are nonprescription substances. This provision also provides that the term does not include preparation of a drug for research, teaching, or chemical analysis, nor does the term include minor deviations from directions when acting under the supervision of a nuclear pharmacist or a physician.

"Anticipatory compounding" is a new definition which means a pharmacy's or practitioner's preparation of a supply of a compounded drug product sufficient to meet the pharmacy's short-term need for filling prescriptions or a practitioner's need for dispensing or administering the drug to patients treated by the practitioner.

"Extemporaneous compounding" is another new definition which means the compounding of a drug product pursuant to a prescription drug order that is issued in advance of the compounding.

Finally, "compounded positron emission tomography drug" is a new definition, which means a drug used for PET scan images, and compounded in compliance with Minnesota Rules for a patient or research, teaching, or quality control.

Scope of Practice Updates
Chiropractors – Article 4, Section 4

Non-controversial changes to the scope of practice were included in the bill. The language updates definitions and regulations of the licensing boards.

Athletic Trainers – Article 4, Sections 14-22

Similar to chiropractors, non-controversial changes to the scope of practice were included in the bill. The language updates definitions and regulations of the licensing boards.

Tanning Beds – Article 6, Sections 24-26
The bill prohibits children under 18 from using commercial tanning equipment, with petty misdemeanor fines for violations. Additionally, warning signs on the dangers of tanning bed use must be posted in tanning salons.

E-Cigarettes – Article 6, Sections 4-7
This provision will ban the use of e-cigarettes in:

- Any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivisions.
- Any facility owned by Minnesota State Colleges and Universities and the University of Minnesota.
- Any facility licensed by the commissioner of Human Services.
- Any facility licensed by the commissioner of Health, but only if the facility is also subject to federal licensing requirements.

Use of e-cigarettes is also prohibited in daycare premises, health care facilities and clinics, and in public schools. E-cigarettes cannot be sold to anyone under the age of 18, and can no longer be sold from kiosks. Cities retain their ability to enforce stricter regulations regarding both sale and use of electronic cigarettes with these changes.

MN Nursing Board Reform – Article 4
The bill includes provisions that would make reforms to allow the Board of Nursing to take more stringent action to protect patients from troubled nurses. The provisions would:

- Allow for automatic suspensions of licensed health care professionals in Minnesota whose behavior presents an imminent risk of harm to their patients. This risk

determination would be assessed by a licensing board of a Health Department commissioner.

- Revoke the licenses of nearly all health care providers convicted of most types of sex crimes. It would also require a 10-year waiting period following a sex offender's release from incarceration before that person could get a license to practice.
- Restructure the drug and mental health monitoring program.
- Require the board to suspend nurses who fail a state drug and mental health monitoring program unless they prove they are not an imminent risk of harm to the public.

Electronic drug prior authorization standardizations and transmission - Article 6, Section 1
The bill changes the date drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions from no later than January 1, 2015, to no later than January 1, 2016.

Notice to Patients; Mammogram Results - Article 6, Section 2
The bill requires a facility at which mammography examinations are performed to send a notice to a patient if the patient was categorized by the facility as having heterogeneously dense breast or extremely dense breasts and provides sample notice language.

OTHER HEALTH CARE POLICY BILLS

ADVANCED PRACTICE REGISTERED NURSES

S.F. 511 – Chapter 235
Senator Kathy Sheran & Representative Dan Schoen
Effective January 1, 2015

This legislation allows advanced practice registered nurses (APRN) - nurses with postgraduate education such as nurse practitioners, clinical nurse specialists, nurse midwives or registered nurse anesthetists – to practice with some independence from doctors. It also creates a separate state licensure for advanced practice nurses.

The separate licensure requires the Minnesota Board of Nursing to approve licensure, along with a certification from a national nurse certification organization acceptable to the board, for practice as an APRN. New licensure begins January 1, 2015. There is a grandfather provision for those meeting certain requirements.

The legislation outlines what each practice consists of, its scope, and level of collaboration with a physician. The following includes the key components.

A clinical nurse specialist (CNS) practice means:
(1) The diagnosis and treatment of health and illness status;
(2) Disease management;
(3) Prescribing pharmacologic and non-pharmacologic therapies;
(4) Ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) Prevention of illness and risk behaviors;
(6) Nursing care for individuals, families, and communities;
(7) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient; and
(8) Integration of care across the continuum to improve patient outcomes.

Collaboration is defined as the process in which two or more health care professionals work together to meet the health care needs of the patient, as warranted by the patient.

A certified nurse-midwife (CNM) practice means:
(1) The management, diagnosis, and treatment of women's primary health care including pregnancy, childbirth, postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women across the life span;
(2) Ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(3) Prescribing pharmacologic and non-pharmacologic therapies; and

(4) Consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

A certified nurse practitioner (CNP) practice means:
(1) Health promotion, disease prevention, health education, and counseling;
(2) Providing health assessment and screening activities;
(3) Diagnosing, treating, and facilitating patients' management of their acute and chronic illnesses and diseases;
(4) Ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) Prescribing pharmacologic and non-pharmacologic therapies; and
(6) Consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

A certified registered nurse anesthetist (CRNA) practice means:
(1) Selecting, obtaining, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures;
(2) Ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(3) Prescribing pharmacologic and non-pharmacologic therapies; and
(4) Consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

*** A registered nurse anesthetist may perform nonsurgical therapies for acute and chronic pain symptoms upon referral and in collaboration with a licensed physician. The CRNA and physician must have a mutually agreed upon plan that designates scope of collaboration necessary for providing nonsurgical therapies to patients with acute and chronic pain. The CRNA must perform the nonsurgical therapies at the same licensed health care facility as the physician. ***

*** The CRNA must have a written prescribing agreement with a licensed physician that outlines the delegated responsibilities related to prescribing drugs and therapeutic devices within the scope of the agreement and the CRNA practice. ***

APRNs are authorized to:
(1) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;
(2) Prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and
(3) Plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic, and supportive services including, but not limited to, home health care, hospice, physical, and occupational therapy.

Population focus categories includes:
Family and individual across the life span, adult gerontology, neonatal, pediatrics, women's and gender-related health, and psychiatric and mental health.

APRN practice is outlined specifically in statute and includes an expanded scope of nursing in at least one of the recognized APRN roles (outlined above) for at least one population focus (outlined above).

APRN scope and practice standards are defined by national professional nursing organizations. The scope includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering.

Prescribing does not include recommending or administering a drug or therapeutic device for anesthesia care by a certified registered nurse anesthetist.

A CNS or CNP who qualifies for APRN licensure must practice for at least 2,080 hours within the context of a collaborative agreement within a hospital or integrated clinical setting where APRNs and physicians work together to provide patient care.

New Advanced Practice Nursing Advisory Council Established:

The Board of Nursing will convene an Advanced Practice Nursing Advisory Council. The seven members will represent:

1) Four Minnesota licensed APRNs (one CNP, one CNM, one CNS, and one CRNA);
2) Two Minnesota licensed physicians who work with APRNs; and
3) One public member who is not a MN license APRN or physician.

The Council's duties include:
1) Review prescribing trends and APRNs at the aggregate level;
2) Review emerging practices and overlap of advanced practice nursing and specialty medical practices in the six population foci and four categories of APRNs;
3) Provide recommendations to the Board of Nursing regarding advance practice nursing;
4) Advise the board on advanced practice registered nurse licensure and practice standards, including emerging practice trends, aggregate prescribing trends, and overlap of advanced practice registered nursing and medical practices;
5) Advise the board on distribution of information regarding advanced practice registered nurse licensure standards; and
6) Advise the board on issues related to advanced practice registered nurse practice and regulation.

The Advanced Practice Nursing Advisory Council will not review complaints or have the power to recommend discipline.

This bill was passed in the House on a vote of 119-13 and in the Senate on a vote of 64-0. Governor Dayton signed this bill into law on May 13, 2014.

The full bill language is included in the Appendix.

MEDICAL CANNABIS

S.F. 2470 – Chapter 311
Senator Scott Dibble & Representative Carly Melin
Effective the day following final enactment.

This program is widely heralded as the strictest in the county. It allows the use of the medical cannabis, if delivered in the form of a liquid (oil), pill, or vaporized delivery method only if used with the liquid or oil. It does NOT allow use of the dried leaves, plant form, or smoking.

A patient registry is set up for Minnesota residents who have been diagnosed by a health care practitioner with a qualifying medical condition. The patient registry will track who is allowed to access medical cannabis. A registered designated caregiver may also be certified to access medical cannabis and assist a patient in its use if they: are 21 years old, do not have a disqualifying felony offense, have been approved by the commissioner to assist the patient with the use of medical cannabis providing a health care practitioner has identified the patient as developmentally disabled, and therefore unable to self-administer the medication.

Qualifying medical conditions eligible for medical cannabis include a diagnosis of any of the following conditions:

- Cancer, if the underlying condition or treatment produces one or more of the following: severe or chronic pain, nausea or severe vomiting, or cachexia or severe wasting;
- Glaucoma;
- Human immunodeficiency virus or acquired immune deficiency syndrome;
- Tourette's syndrome;
- Amyotrophic lateral sclerosis;
- Seizures - including those characteristic of epilepsy;
- Sever and persistent muscle spasms, including those characteristics of multiple sclerosis;
- Crohn's disease;
- Terminal illness, with a probable life expectancy of under one year; or
- Any other medical condition or its treatment approved by the commissioner.

If the Commissioner recommends adding a medical condition to the list of those approved for use of medical cannabis, the Commissioner must notify the Legislature of the recommendation of the addition and the reasons for its additional by January 15; the change becomes effective August 1 unless the legislature by law provides otherwise. The Commissioner must first review whether it should add intractable pain to the list of eligible conditions.

The Commissioner may prohibit a patient from enrollment in the registry if they are simultaneously enrolled in a federal clinic trial for the treatment of a qualifying medical condition with medical cannabis.

The Commissioner shall register two manufactures by December 1, 2014. Each manufacturer must operate four distribution facilities, one which must be able to distribute medical cannabis by July 1, 2015. The manufacturer shall require that employees licensed as a pharmacist be the employees to distribute medical cannabis to patients.

The Commissioner is in charge of all rulemaking to administer this program.

The patient registry established by the Commissioner will evaluate data on patient demographics, effective treatment options, clinical outcome, and quality-of-life outcome for the purpose of reporting benefits, risks, and outcomes regarding patients with a qualifying medical condition engaged in the therapeutic use of medical cannabis.

The Commissioner shall conduct research and studies based on data from the health records submitted to the patient registry and submit reports or intermediate or final research results to the legislature and major scientific journals.

There are legal protections for patients allowing a presumption (rebuttable) that the patient is enrolled in the registry program and is engaged in the authorized use of medical cannabis. New crimes include: felony offenses for intentional diversion of medical cannabis by manufacturers, patients, registered designated caregivers or parents; misdemeanor offense for intentionally making false statements to a law enforcement official about facts/circumstances relating to the medical use of cannabis to avoid arrest/prosecution.

Nursing facilities may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at the facility.

Patient enrollment fee is $200, annually. Some individuals may be eligible for a lower fee of $50. Each manufacturer application fee is $20,000, with an additional annual fee for regulation and inspecting their facilities.

A 23-member Task Force on medical cannabis therapeutic research is created to conduct an impact assessment of medical cannabis therapeutic research. Task Force membership includes: legislators, consumer and patient representatives, health care providers, law enforcement, substance use treatment providers, and the commissioners of health, human services and public safety.

The Task Force shall hold hearings to conduct as assessment that evaluates the impact of the use of medical cannabis, Minnesota's activities, other states' activities and offer analysis. They must report their findings to the legislature.

The bill passed the House on a vote of 89-40 and passed the Senate on a vote of 46-16. Governor Dayton signed the bill into law on Thursday, May 29, 2014.

ALL PAYER CLAIMS DATABASE

H.F. 2656 – Chapter 178
Representative Tom Huntley & Senator Tony Lourey
Effective the day following final enactment.

This legislation requires the Commissioner of Health to develop a peer grouping system for providers that incorporates risk-adjusted cost of care and quality of care. As part of the provider peer grouping process, health plan companies and third-party administrators are required to submit encounter and pricing data to an entity designated by the commissioner of health. The

commissioner is allowed to use the data submitted only to carry out responsibilities related to administering the provider peer grouping system.

It also suspends the development and implementation of the provider peer grouping system, expands the allowable uses of the encounter and pricing data submitted, requires the commissioner to work with vendors to assess encounter data and ensure data quality, and establishes a work group to develop a framework for the expanded use of the all-payer claims data base.

The bill was passed by the House on a vote of 80-48 and passed the Senate on a vote of 46-13. Governor Dayton signed the bill into law on April 29, 2014.

The full bill language is included in the Appendix.

NEWBORN SCREENING

S.F. 2047 – Chapter 203
Senator John Marty & Representative Kim Norton
Effective August 1, 2014

This legislation allows the state to keep newborn blood samples indefinitely, unless a parent requests the sample be destroyed. Currently, the Department of Health's newborn screening program tests babies for rare disorders through a blood spot test taken when the baby is 24 to 48 hours old. The program includes testing for hearing loss and congenital heart disease, among many other health conditions. The department keeps blood spots for 71 days when test results are negative for a disorder and 24 months for positive results. These storage limitations are in place unless the department receives written consent from the parents to store the blood spots and test results for an extended period of time.

With this new law, the department is allowed to store blood spots and test results indefinitely unless parents ask to have the information destroyed, a request parents could make at any time using required forms. Individuals could request at age 18 to have their own results destroyed.

The legislation also includes other potential changes to the storage of blood spots and test results and consent.

Parents could refuse screening or they could choose to allow newborn screening, but refuse storage of blood spots or test results. If parents decide against the test or storage, they would need to complete the required form and the department would destroy blood spots within 30 days and test results within 30 days or the earliest time according to federal laboratory regulations.

The department would be able to use blood spots and test results for public health research and research unrelated to newborn screening only if parents provide written consent for such research. Additionally, the department would have authority to use the blood spots and test results to develop more newborn screening tests and for "studies related to newborn screening."

The bill passed the House on a vote of 69-58 and passed the Senate on a vote of 36-20. Governor Dayton signed the bill into law on May 5, 2014.

SYNTHETIC DRUGS

H.F. 2446 – Chapter 285
Representative Erik Simonson & Senator Roger Reinert
Effective August 1, 2014

This legislation was aimed at reducing the manufacture and distribution of synthetic drugs in the state and contained a number of recommendations from the bipartisan House Select Committee on Controlled Substances and Synthetic Drugs.

The bill expands the definition of drug to include any compound, substance, or derivative that is not approved for human consumption by the United States Food and Drug Administration or specifically permitted for human consumption under Minnesota law, and, when introduced into the body, induces an effect similar to that of a Schedule I or Schedule II controlled substance, regardless of whether the substance is marketed for the purpose of human consumption. It gives the Pharmacy Board cease and desist authority to prevent the sale of synthetic drugs and modifies laws governing misbranding or adulterated drugs. It provides mandatory restitution when a person is convicted for selling controlled substance under false pretenses. Finally, it establishes a public education plan and awareness campaign to promote knowledge of the dangers of synthetic drugs.

The bill passed the House on a vote of 129-0 and passed the Senate on a vote of 55-2. Governor Dayton signed the bill into law on May 21, 2014.

STEVE'S LAW

S.F. 1900 – Chapter 232
Senator Chris Eaton and Representative Dan Schoen
Effective Various Dates

This legislation permits licensed prescribers (physicians, advanced practice registered nurses, and physician assistants) to authorize the following individuals to administer opiate antagonists (narcan): emergency medical responders, peace officers, and staff of community-based health disease prevention or social service programs. Opiate antagonists have the ability to save lives of individuals experiencing a drug overdose. Allowing these first responders to administer this treatment will result in more timely treatment in these time sensitive situations.

Additionally, the bill specifies that the individual experiencing an overdose and those who seek medical assistance for another person experiencing an overdose may not be prosecuted, penalized, or have property subject to civil forfeiture.

The bill passed the House on a vote of 130-0 and passed the Senate on a vote of 65-0. Governor Dayton signed the bill into law on May 9, 2014.

DHS OFFICE OF INSPECTOR GENERAL

S.F. 1340 – Chapter 228
Senator Jeff Hayden & Representative Jim Abeler
Effective the day following enactment.

This legislation establishes a task force under the Commissioner of Health to provide recommendations to integrate foreign-trained physicians into Minnesota's health care system.

The task force will develop strategies to integrate refugee and asylee physicians into the Minnesota health care delivery system by doing the following:

- Analyze demographic information of current medical providers compared to the population of the state;
- Identify, to the extent possible, foreign-trained physicians living in Minnesota who are refugees or asylees and interested in meeting the requirements to enter medical practice or other health careers;
- Identify costs and barriers associated with integrating foreign-trained physicians into the state workforce;
- Explore alternative roles and professions for foreign trained physicians who are unable to practice as physicians in the Minnesota health care system; and
- Identify possible funding sources to integrate foreign-trained physicians into the state workforce as physicians or other health professionals.

The task force must submit recommendations to the Commissioner of Health by January 15, 2015.

This bill was passed by the Senate back in the 2013 Legislative Session on a vote of 60-0. It passed the House this session on a vote of 129-0. Governor Dayton signed the bill into law on May 9, 2014.

HEALTH CARE COORDINATION BILL

H.F. 824 / S.F. 970
Representative Melissa Hortman & Senator Tony Lourey
This legislation did NOT pass.

This legislation proposed to align the Minnesota Health Records Act with the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The bill would have created uniform, predictable, and administratively manageable standards for sharing clinically appropriate medical information between providers treading the same patient, thus improving the quality of patient care in Minnesota. This is an issue which was mentioned in the Minnesota's Health Care Reform Task Force report to the Governor in 2012.

There is currently a lag in record sharing under current state law, which at times creates a delay in patient care. Minnesota is one of a handful of states that imposes consent requirements in

addition to HIPAA. In recent years, a number of those states have implemented laws similar to H.F. 824.

This bill ensures that health care providers can share clinically appropriate data while maintaining data privacy. Ultimately this leads to effective treatment, an increase in quality care, and affordable care costs.

REGULATORY REFORM

WORKERS' COMPENSATION ADVISORY COUNCIL

H.F. 2658 – Chapter 182
Representative Tim Mahoney & Senator Dan Sparks
Effective Various Dates

A piece of legislation, which included some technical changes to worker's compensation statutes, passed this session. This bill included changes that were recommended to legislature by the state Workers' Compensation Advisory Council. This bill did not, however, include any reforms to reimbursement.

The next meeting of the Workers' Compensation Advisory Council will be held on June 11th. The Commissioner of the Department of Labor has indicated major changes could be in store for the 2015 legislative session.

Provisions in the bill include changes to:

- Occupational disease (Minnesota Statutes 2013 Supplement, section 176.011);
- Payments to fund (Minnesota Statutes 2012, section 176.129);
- Refunds (Minnesota Statutes 2012, section 176.129);
- Medical bills and records (Minnesota Statutes 2012, section 176.135);
- Relative value fee schedule (Minnesota Statutes 2012, section 176.136);
- Initial report, written report (Minnesota Statutes 2012, section 176.231);
- Settlement and pretrial conferences; summary decision (Minnesota Statutes 2012, section 176.305); and
- Repeals Minnesota Statutes 2012, sections 175.006, subdivision 1; 175.08; 175.14; 175.26; 176.1311; 176.136, subdivision 3; 176.2615; and 176.641.

SUPPLEMENTAL BUDGET BILL - WORKERS' COMPENSATION FUNDING

H.F. 3172 – Chapter 312
Representative Lyndon Carlson & Senator Chuck Wiger
Effective Various Dates

Sec. 15. ***WORKERS' COMPENSATION SYSTEM REFORM; USE OF FUNDS.***
(a) The appropriations under section 14 to the commissioner of labor and industry are for reform of the workers' compensation system. Funds appropriated under section 14, paragraphs (c) and (d), may be expended by the commissioner only after the advisory council on workers' compensation created under Minnesota Statutes, section 175.007, has approved a new system including, but not limited to: a Medicare-based diagnosis-related group (MS-DRG) or similar system for payment of workers' compensation inpatient hospital services. Of the amount appropriated under section 14, paragraphs (c)

and (d), up to $100,000 may be used by the commissioner to develop and implement the new system approved by the advisory council on workers' compensation.
(b) Funds available for expenditure under paragraph (a) may be used by the commissioner for reimbursement of expenditures that are reasonable and necessary to defray the costs of the implementation by hospitals, insurers, and self-insured employers of the new system including, but not limited to: a Medicare-based diagnosis-related group (MS-DRG) or similar system for payment of workers' compensation inpatient hospital services, litigation expense reform, worker safety training, administrative costs, or other related system reform.
(c) For the purposes of this section, reasonable and necessary system reform and implementation costs include, but are not limited to:
(1) the cost of analyzing data to determine the anticipated costs and savings of implementing the new system;
(2) the cost of analyzing system or organizational changes necessary for implementation;
(3) the cost of determining how an organization would implement group or other software;
(4) the cost of upgrading existing software or purchasing new software and other technology upgrades needed for implementation;
(5) the cost of educating and training staff about the new system as applied to workers' compensation; and
(6) the cost of integrating the new system with electronic billing and remittance systems.

FRAUD PREVENTION LEGISLATION

H.F. 3073 – Chapter 310
Representative Joe Atkins & Senator Vicki Jensen
Effective Various Dates.

The Minnesota Senate created a bi-partisan group of Senators that met monthly during last year's interim. A consensus bill was drafted however, and after much last minute negotiation, the conference committee came to an agreement on bill language, removing a number of provisions in the bill as introduced. These provisions were removed due to concerns raised by the trial attorneys. The provisions that remain in the bill include:

Regulation of Trade Practices; Insurance Contract Data

Section 1. Minnesota Statutes 2012, section 13.7191, subdivision 16, is amended to read:
Subd. 16. Regulation of trade practices; insurance contract data. ~~(a) Insurance contract data.~~ Certain insurance contract data held by the commissioner of commerce are classified under section 72A.20, subdivision 15.
~~(b) Health claims appeals. Documents that are part of an appeal from denial of health care coverage for experimental treatment are classified under section 72A.327.~~

Immunity From Liability

Sec. 2. Minnesota Statutes 2012, section 60A.952, subdivision 3, is amended to read:
Subd. 3. ***Immunity from liability.*** *If insurers, insurance support organizations as defined in section 72A.491, subdivision 12, agents acting on the insurers' behalf, or authorized persons release information in good faith under this section, whether orally or in writing, they are immune from any liability, civil or criminal, for the release or reporting of the information.*

Sec. 9. Minnesota Statutes 2012, section 72A.502, subdivision 2, is amended to read:
Subd. 2. ***Prevention of fraud.*** *Personal or privileged information may be disclosed without a written authorization to another person if the information is limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction, and that person agrees not to disclose the information further without the individual written authorization unless the further disclosure is otherwise permitted by this section if made by an insurer, insurance agent, or insurance-support organization. Any insurer, insurance agent, or insurance-support organization making such a disclosure is immune from liability under section 60A.952, subdivision 3.*

Medical Expense Benefits Change Regarding Prescription Drugs

Sec. 3. Minnesota Statutes 2012, section 65B.44, subdivision 2, is amended to read:
Subd. 2. ***Medical expense benefits.*** *(a) Medical expense benefits shall reimburse all reasonable expenses for necessary:*
(1) medical, surgical, x-ray, optical, dental, chiropractic, and rehabilitative services, including prosthetic devices;
(2) prescription drugs, provided that:
(i) prescription drugs filled and dispensed outside of a licensed pharmacy shall be billed at the average wholesale price (AWP), or its equivalent, for that drug on that date as published in Medispan, Redbook, or Gold Standard Drug Database, as identified by its National Drug Code, plus a dispensing fee of $4.18;
(ii) if a prescription drug has been repackaged, the average wholesale price used to determine the maximum reimbursement shall be the average wholesale price for the underlying drug product, as identified by its National Drug Code from the original labeler; and
(iii) compound drugs shall be billed by listing each drug and its National Drug Code number included in the compound and calculating the charge for each drug separately. Reimbursement shall be based on the sum of the fee for each ingredient for which there is an assigned National Drug Code number plus a single dispensing fee of $4.18. Compound drugs shall not be dispensed without first obtaining preauthorization from the reparation obligor;
(3) ambulance and all other transportation expenses incurred in traveling to receive other covered medical expense benefits;
(4) sign interpreting and language translation services, other than such services provided by a family member of the patient, related to the receipt of medical, surgical, x-ray, optical, dental, chiropractic, hospital, extended care, nursing, and rehabilitative services; and
(5) hospital, extended care, and nursing services.
(b) Hospital room and board benefits may be limited, except for intensive care facilities, to the regular daily semiprivate room rates customarily charged by the institution in which the recipient of benefits is confined.
(c) Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of this state for an injured person who relies upon spiritual means through prayer alone for healing in accordance with that person's religious beliefs.
(d) Medical expense loss includes medical expenses accrued prior to the death of a person

notwithstanding the fact that benefits are paid or payable to the decedent's survivors.
(e) Medical expense benefits for rehabilitative services shall be subject to the provisions of section 65B.45.

Increase Disability And Income Loss Benefits

Sec. 4. Minnesota Statutes 2012, section 65B.44, subdivision 3, is amended to read:
Subd. 3. ***Disability and income loss benefits.*** *(a) Disability and income loss benefits shall provide compensation for 85 percent of the injured person's loss of present and future gross income from inability to work proximately caused by the nonfatal injury subject to a maximum of ~~$250~~ $500 per week. Loss of income includes the costs incurred by a self-employed person to hire substitute employees to perform tasks which are necessary to maintain the income of the injured person, which are normally performed by the injured person, and which cannot be performed because of the injury.*
(b) If the injured person is unemployed at the time of injury and is receiving or is eligible to receive unemployment benefits under chapter 268, but the injured person loses eligibility for those benefits because of inability to work caused by the injury, disability and income loss benefits shall provide compensation for the lost benefits in an amount equal to the unemployment benefits which otherwise would have been payable, subject to a maximum of ~~$250~~ $500 per week.
(c) Compensation under this subdivision shall be reduced by any income from substitute work actually performed by the injured person or by income the injured person would have earned in available appropriate substitute work which the injured person was capable of performing but unreasonably failed to undertake.
(d) For the purposes of this section "inability to work" means disability which prevents the injured person from engaging in any substantial gainful occupation or employment on a regular basis, for wage or profit, for which the injured person is or may by training become reasonably qualified. If the injured person returns to employment and is unable by reason of the injury to work continuously, compensation for lost income shall be reduced by the income received while the injured person is actually able to work. The
weekly maximums may not be prorated to arrive at a daily maximum, even if the injured person does not incur loss of income for a full week.
(e) For the purposes of this section, an injured person who is "unable by reason of the injury to work continuously" includes, but is not limited to, a person who misses time from work, including reasonable travel time, and loses income, vacation, or sick leave benefits, to obtain medical treatment for an injury arising out of the maintenance or use of a motor vehicle.
EFFECTIVE DATE.*This section is effective January 1, 2015.*

Increase Funeral Expenses

Sec. 5. Minnesota Statutes 2012, section 65B.44, subdivision 4, is amended to read:
Subd. 4. ***Funeral and burial expenses.*** *Funeral and burial benefits shall be reasonable expenses not in excess of ~~$2,000~~ $5,000, including expenses for cremation or delivery under the Darlene Luther Revised Uniform Anatomical Gift Act, chapter 525A.*
EFFECTIVE DATE.*This section is effective January 1, 2015.*

Increase Survivor Economic Loss Benefits

Sec. 6. Minnesota Statutes 2012, section 65B.44, subdivision 6, is amended to read:
Subd. 6. ***Survivors economic loss benefits.*** *Survivors economic loss benefits, in the event of death occurring within one year of the date of the accident, caused by and arising out of injuries received in the accident, are subject to a maximum of ~~$200~~ $500 per week and shall cover loss accruing after decedent's death of contributions of money or tangible things of economic value, not including services, that surviving dependents would have received from the decedent for their support during their dependency had the decedent not suffered the injury causing death.*
For the purposes of definition under sections 65B.41 to 65B.71, the following described persons shall be presumed to be dependents of a deceased person: (a) a wife is dependent on a husband with whom she lives at the time of his death; (b) a husband is dependent on a wife with whom he lives at the time of her death; (c) any child while under the age of 18 years, or while over that age but physically or mentally incapacitated from earning, is dependent on the parent with whom the child is living or from whom the child is receiving support regularly at the time of the death of such parent; or (d) an actual dependent who lives with the decedent at the time of the decedent's death. Questions of the existence and the extent of dependency shall be questions of fact, considering the support regularly received from the deceased. Payments shall be made to the dependent, except that benefits to a dependent who is a child or an incapacitated person may be paid to the dependent's surviving parent or guardian. Payments shall be terminated whenever the recipient ceases to maintain a status which if the decedent were alive would be that of dependency.
EFFECTIVE DATE.*This section is effective January 1, 2015.*

Economic Loss Benefits; Exemptions from Legal Attachment

Sec. 8. Minnesota Statutes 2012, section 65B.57, is amended to read:
65B.57 ECONOMIC LOSS BENEFITS; EXEMPTIONS FROM LEGAL ATTACHMENT.
(a) All economic loss benefits provided by sections 65B.41 to 65B.71, whether paid or payable to any claimant shall not be subject to garnishment, sequestration, attachment or execution, or any other legal process which would deny their receipt and use by that person~~; provided, however, that~~.
(b) This section shall not apply to any person who has provided treatment or services, as described in section 65B.44, subdivision 2, to the victim of a motor vehicle accident.
(c) Economic loss benefits paid or payable to any claimant, person, or entity who has provided treatment or services under sections 65B.41 to 65B.71 shall not be subject to any legal interest in the payment, whether by contract, lien, or other legal process before a denial of benefits by a reparations obligor.
EFFECTIVE DATE.*This section is effective the day following final enactment.*

Mandatory Submission to Binding Arbitration.

Sec. 7. Minnesota Statutes 2012, section 65B.525, subdivision 1, is amended to read:
Subdivision 1. ***Mandatory submission to binding arbitration.*** *~~Except as otherwise provided in section 72A.327,~~ The Supreme Court and the several courts of general trial jurisdiction of this state shall by rules of court or other constitutionally allowable device, provide for the mandatory submission to binding arbitration of all cases at issue where the claim at the commencement of arbitration is in an amount of $10,000 or less against any insured's reparation obligor for no-fault benefits or comprehensive or collision damage coverage.*

Task Force On Motor Vehicle Insurance Coverage Verification.

Sec. 10. ***TASK FORCE ON MOTOR VEHICLE INSURANCE COVERAGE VERIFICATION.***
Subdivision 1. ***Establishment.*** *The task force on motor vehicle insurance coverage verification is established to review and evaluate approaches to insurance coverage verification and recommend legislation to create and fund a program in this state.*
Subd. 2. ***Membership; meetings; staff.*** *(a) The task force shall be composed of 14 members, who must be appointed by July 1, 2014, and who serve at the pleasure of their appointing authorities:*
(1) the commissioner of public safety or a designee;
(2) the commissioner of commerce or a designee;
(3) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;
(4) two members of the senate, one appointed by the Subcommittee on Committees of the Committee on Rules and Administration and one appointed by the minority leader;
(5) a representative of Minnesota Deputy Registrars Association;
(6) a representative of AAA Minnesota;
(7) a representative of AARP Minnesota;
(8) a representative of the Insurance Federation of Minnesota;
(9) a representative of the Minnesota Bankers Association;
(10) a representative of the Minnesota Association for Justice;
(11) a representative of the Minnesota Police and Peace Officers Association; and
(12) a representative of the Minnesota chapter of the International Association of Special Investigation Units.
(b) Compensation and expense reimbursement must be as provided under Minnesota Statutes, section 15.059, subdivision 3, to members of the task force.
(c) The commissioner of public safety shall convene the task force by August 1, 2014, and shall appoint a chair from the membership of the task force. Staffing and technical assistance must be provided by the Department of Public Safety.
Subd. 3. ***Duties.*** *The task force shall review and evaluate programs established in other states as well as programs proposed by third parties, identify one or more programs recommended for implementation in this state, and, as to the recommended programs, adopt findings concerning:*
(1) comparative costs of programs;
(2) implementation considerations, and in particular, identifying the appropriate supervising agency and assessing compatibility with existing and planned computer systems;
(3) effectiveness in verifying existence of motor vehicle insurance coverage;
(4) identification of categories of authorized users;
(5) simplicity of access and use for authorized users;
(6) data privacy considerations;
(7) data retention policies; and
(8) statutory changes necessary for implementation.
Subd. 4. ***Report.*** *By February 1, 2015, the task force must submit to the chairs and ranking minority members of the house of representatives and senate committees and divisions with primary jurisdiction over commerce and transportation its written recommendations, including any draft legislation necessary to implement the recommendations.*
Subd. 5. ***Sunset.*** *The task force shall sunset the day after submitting the report under subdivision 4, or February 2, 2015, whichever is earlier.*
EFFECTIVE DATE.*This section is effective the day following final enactment.*

SURVIVORSHIP OF LAWSUITS

S.F. 693 / H.F. 482
Senator Kari Dziedzic & Representative Joe Atkins
This legislation did NOT pass.

This legislation would add a costly new class of damages in wrongful death cases. It would permit family members of a decedent to recover pain and suffering that were personal to the decedent. This would change a law that has been settled in Minnesota since 1849. While there is a majority of states which allow lawsuits to survive the death of a party, a majority also places a cap on damages or limit cases to pending actions.

TAXES

OMNIBUS TAX BILL #1

H.F. 1777 – Chapter 150
Representative Ann Lenczewski & Senator Rod Skoe
Effective various dates

Based on an agreement reached by Governor Dayton and legislative leaders, the first Omnibus Tax Bill contained over $430 million in tax relief and put $150M into the budget reserves.

Included in this bill were provisions that:

- Conform Minnesota's individual income tax and corporate franchise tax on an ongoing basis retroactively to tax year 2013 to most federal changes enacted since April 14, 2011, with conformity delayed until tax year 2014 for the increased standard deduction for married filers.
    - Minnesota would not conform to increased section 179 expensing and increased bonus depreciation, which federal law extended to tax year 2013 only.
- Repeal the imposition of sales tax on the following business purchases retroactively:
    - Repair labor for electronic and precision equipment;
    - Repair labor for commercial and industrial equipment (including farm equipment); and
    - Storage and warehousing services (currently not taxable until April 1, 2014).
- Reinstate and expand the exemption for capital equipment used in providing telecommunication and pay television services. The exemption will now cover poles, wire, cable, fiber, and conduit.

This plan, proposed by the Senate, was passed on a vote of 58-5. The House quickly voted to concur, because they felt pressure to get the bill signed into law quickly so filers could take advantage. The bill passed the House on a vote of 128-2 and the bill was signed into law by the Governor on March 21, 2014.

OMNIBUS TAX BILL #2

H.F. 3167 – Chapter 308
Representative Ann Lenczewski & Senator Rod Skoe
Effective various dates

The second Omnibus Tax Bill provided $103 million in tax cuts, including property tax reductions for homeowners, renters and farmers.

The bill provides homeowners with a one-time increase in the Homestead Credit Refund for taxes payable in 2014. Each and every homeowner receiving a refund will see a 3 percent increase, providing an additional $12.1 million in property tax relief to 500,000 Minnesota

homeowners. The average homeowner will see a refund of $837 for 2014. This comes on top of the $133 million in direct property tax relief passed in 2013 for homeowners and renters.

The bill also provides renters with a one-time increase in the Renters' Credit Refunds paid in 2014. Each and every renter receiving a refund will see a 6 percent increase, providing an additional $12.5 million in property tax relief to 350,000 Minnesota renters. The average renter will see a refund of $643.This comes on top of the $133 million in direct property tax relief passed in 2013 for homeowners and renters.

Of significant interest, the bill includes a couple modifications in exemptions for purchases covered by Medicare or Medicaid. These provisions are:

Effective Date – Durable Medical Equipment and Drugs.

The bill modifies the effective date in the 2013 omnibus tax bill for the exemption of purchases covered by Medicare or Medicaid, to be retroactive for sales and purchases made after April 1, 2009, and allows a refund for the period April 1, 2009 to July 1, 2013, if the tax was paid by the vendor but never collected from the purchaser. The refund request must be filed by June 30, 2015.

Effective Date – Medical Supplies and Accessories.

The bill modifies the effective date in the 2013 omnibus tax bill for the exemption of purchases covered by Medicare or Medicaid, to be retroactive for sales and purchases made after April 1, 2009, and allows a refund for the period April 1, 2009 to July 1, 2013, if the tax was paid by the vendor but never collected from the purchaser. The refund request must be filed by June 30, 2015.

On the last day of session, the House passed this legislation unanimously on a vote of 131-0. Shortly after the House vote, the Senate took the bill up where it passed on a vote of 59-1. Governor Dayton signed the bill into law on May 20, 2014.

The full bill language of the effective date provisions is included in the Appendix.

OTHER BILLS TO PASS THIS SESSION

BONDING BILLS

H.F. 2490 (Chapter 294) & H.F. 1068 (Chapter 295)
Representative Alice Hausman & Senator LeRoy Stumpf
Effective the day following enactment, unless otherwise provided.

The House and Senate passed a pair of capital investment bills that will spend nearly $1.05 billion on projects across the state. HF2490 spends $846 million in general-obligation bonding and HF1068 spends $198.7 million from the state's budget surplus for additional infrastructure projects. The bills jointly contain:

- Over $275 million for higher education
- $126 million for the restoration of the Capitol
- $100 million for transportation and transit projects
- $100 million for housing investments
- $175 million invested in economic development projects
- $70 million for water infrastructure projects

While the cash bill needed just a simple majority, the general-obligation bonding bill needed to garner support from three-fifths of members to pass. The House passed HF2490 on a vote of 92-40, and HF1068 on a vote of 82-50. The Senate Passed HF2490 on a vote of 47-17, and HF1068 on a vote of 44-19. The bills were signed into law on May 20, 2014.

BULLYING BILL

H.F. 826 – Chapter 160
Representative Jim Davnie & Senator Scott Dibble
Effective various dates

A controversial anti-bullying measure became law in early April. This legislation requires schools to track and investigate cases of bullying and train teachers and staff to prevent it.

MINIMUM WAGE

H.F. 2091 – Chapter 166
Representative Ryan Winkler & Senator Jeff Hayden
Effective August 1, 2014

Since the beginning of session, a House-Senate Conference Committee was meeting to negotiate an increase to Minnesota's minimum wage. The Minnesota wage hasn't gone up since 2005. Currently, Minnesota's minimum wage for all but the smallest of businesses is $6.15 per hour, though many workers automatically receive the higher federal minimum of $7.25 per hour.

After months of negotiations, the conference committee reached an agreement. Details of the agreement include:

- $8 minimum hourly wage for businesses with gross sales of at least $500,000 in August 2014, $9 in August 2015 and $9.50 one year later;
- $6.50 minimum hourly wage for businesses under $500,000 in gross sales in 2014, $7.25 in August 2015 and $7.75 one year later;
- The $7.75 minimum wage rate would also apply for large businesses in the following circumstances: 90-day training wage for 18 and 19 year olds, all 16 and 17 year olds and employees working under a J1 visa;
- Beginning in 2018, all wages would increase each year on January 1 by inflation measured by the implicit price deflator capped at 2.5 percent; and
- The indexed increase could be suspended for one year by the commissioner of the Department of Labor and Industry if leading economic indicators suggest the possibility of a substantial downturn in the economy. The suspension could only be implemented after a public hearing and public comment period. In better economic times, the suspended inflationary increase or a lesser amount could be added back into the minimum wage rate in a subsequent year.

The bill passed the House on a vote of 71-60 and passed the Senate on a vote of 35-31. Governor Dayton signed the bill into law on April 14, 2014.

SENATE OFFICE BUILDING

The House and Senate agreed to move forward on plans for a new Senate office building behind the Capitol. The plans include a nearly $77 million building to house all senators and allow for new meeting rooms.

WOMEN'S ECONOMIC SECURITY ACT

HF2536 – Chapter 239
Representative Carly Melin & Senator Sandra Pappas
Effective various dates

The Women's Economic Security Act takes steps to close the gender pay gap, providing ways to bring women into higher wage, higher-impact careers, or jobs that are dubbed "traditionally male." Under the bill, parents would be allowed to take 12 weeks instead of the current six for pregnancy and parenting leave in conjunction with a child's birth or adoption. Pregnant women would be entitled to reasonable accommodations to protect their well-being. Nursing mothers would be assured private space to express their milk. Also, "familial status" would be added to laws guarding against unfair employment practices, aimed at preventing women from being bypassed for promotions over doubts about their dedication to career over family.

A few provisions include:

- Expanding unpaid leave under the Minnesota Parental Leave Act from six to 12 weeks and allowing the use of leave under the Parental Leave Act for pregnancy-related needs;
- Allowing mothers to stay in the workforce by expanding family leave and providing reasonable accommodations for pregnant and nursing employees;
- Decreasing the gender pay gap through the participation of women in high-wage, high-demand occupations in fields such as science, technology, engineering, and math;
- Supporting the development of high economic impact women-owned businesses in nontraditional industries;
- Requiring private sector businesses with 40 or more employees seeking state contracts over $500,000 to certify no pay gaps exist between employee classes as defined in the EEO-1 Report (formally known as the "Employer Information Report"), a government form requiring many employers to provide a count of their employees by job category and then by ethnicity, race and gender;
- Allowing grandparents to use existing earned sick leave to care for an ill or injured grandchild;
- Addressing negative economic consequences of domestic violence, stalking and sexual assault;
- Expanding unemployment insurance eligibility currently available to victims of domestic violence to include victims of stalking and sexual assault;
- Allowing employees to use existing earned sick leave to recover from sexual assault, domestic violence, or stalking; and
- Enhancing retirement security by considering a state retirement savings plan for those without an employer-provided option.

The bill passed the House on a vote of 104-24 and passed the Senate on a vote of 43-24. Governor Dayton signed the bill into law on May 11, 2014 – Mother's Day.

UNSESSION BILLS

Governor Dayton's agenda for the year was an "unsession," geared at giving the state's law books a good spring cleaning, purging outdated or duplicative laws. One of the main goals was to speed up delivery and reduce permitting wait time in the process. An effort was also made to encourage state agencies to use clear and simple language whenever possible, emphasizing improvements to state documents, forms and websites. By the end of session, the legislature approved the repeal of over 1,175 obsolete laws and removed over 30 advisory boards that had outlived their purpose.

MMGMA 2014 LEGISLATIVE AGENDA

Payment Methodology for Release of Information (ROI)

Did Not Pass

Support enhanced reimbursement for the initial work required prior to releasing a patient's records. Support a reduction in the per page copying fee.

Any release of protected health information (PHI) must only be made after a careful analysis of privacy issues and making the determination of whether or not the patient has authorized the release. Additional precautions must be taken if legal issues such as guardianship, joint legal custody of children or mental health records are involved. Patient records contain sensitive information and HIPAA privacy rules require careful handling of patient records. A complete search of all records, including paper, electronic and microfiche is then undertaken. Finally records must be assembled, duplicated and sent. These tasks are done by highly trained professionals and require a significant investment of time to insure that patients' rights are protected and regulations are followed.

Oppose the Repeal or Delay of the Provider Tax Phase Out

Did Not Pass

We oppose the use of the proceeds of the Provider Tax for purposes other than MinnesotaCare and further support the continued phase out of the Provider Tax.

In 2012 a bi-partisan proposal to phase out the Provider Tax by 2019 was successfully passed. It was first thought that with the expansion of Medical Assistance under the Affordable Care Act, MinnesotaCare would see a significant reduction in covered lives permitting the phase out of the Provider Tax to proceed, starting in 2014. However, there is now a significant projected shortfall for MinnesotaCare and indications from legislators suggest that there will be an effort to repeal the provider tax phase out.

Oppose Workers' Compensation and No-Fault Fee Reductions

Did Not Pass

Oppose efforts to reduce provider reimbursement in the workers' compensation and no-fault systems.

Treating patients who have been injured on the job or in an auto collision requires many complicated and time consuming administrative activities that are not required when treating other patients. The health care costs in these systems represent approximately only one third of the workers compensation premium and less than 10% of the automobile premium. Reducing provider reimbursement would likely create access issues for these patients.

Proper Notice to Providers of Changes to Contract Terms, Policies, Procedures and Fee Schedules

Introduced SF2971/HF 3354 – Did Not Pass

Support statutory changes which require notification and consent by providers of changes to contract terms, policies and procedures, and fee schedules.

Changes in health plan's policies and procedures should not be effective without notice and clinic consent. Health plans may need to change policies and procedures (ie billing practices, lab fee schedules, and clinic staff time payment changes), however, they should not become effective until notice is properly given to the providers. This change will provide greater efficiency for the entire system so that out of date billings (including timely notice of claim adjustment deadlines) and practices don't result in additional and duplicative staff time, billing efforts, and appeal wait times, all because passive amendments are allowed or contract terms changed without notice and often times not known by the provider. We also support a change that requires 165 days notice by health plans of their fee schedule changes. In turn, this allows providers 45 days to review the contract and fees schedules and make informed decisions about partnering with health plans.

Any Willing Provider – Network Participation

Did Not Pass

Support efforts to ensure state and federal laws are followed related to health plans granting network participation to health care providers who accept and meet insurer's terms and conditions.

State and Federal laws prohibit discrimination against willing providers who meet the terms and conditions for participating in health plan networks. However, health plans often deny providers network participation on that basis that they have sufficient geographical network coverage to meet the state requirements and the needs of the health plan's members. We support clarification that if a provider meets all state and federal licensing and regulatory requirements they cannot be excluded from participating in a health plan network. Alternatively, we support an appeals process handled by the state if a provider is denied into a network. This will assure patients continue to have access to and choice of health care providers. Furthermore, this will provide greater transparency and accountability for the public and providers to ensure fair rules and criteria are applied with respect to network participation.

Risk Sharing Between Insurers and Providers for High Deductible Products

Did Not Pass

Health plans are the first line of interaction with consumers when providing insurance and thus when consumers fall short of their health insurance deductible payments, greater risk sharing between health plans and providers is needed.

Health plans enter into contractual agreements with consumers. With the greater purchase of high deductible health plans coming on the market, providers will be left to collect payments from consumers up to the maximum deductible.

Patient Focused Initiative -- Preventing Opioid Abuse

Passed

We support reducing the harm of the growing abuse and misuse of opioids while protecting physician's autonomy to treat patients in a manner they believe is best.

A special task force was initiated by the Minnesota Medical Association (MMA) and included physicians focused on opioid abuse. Opioids and other painkillers when taken as prescribed manage pain quite effectively and can improve quality of life for people with chronic pain. However abuse and illegal trafficking has become a growing concern and we support working with the MMA and state policy makers to find common sense approaches to address opioid abuse and illegal trafficking while not limiting access to patients who need those therapies.

Support Continued Improvements to Comprehensive Stroke Center Legislation

Passed

Legislation was passed last year to certify Minnesota hospitals as Comprehensive Stroke Centers or Primary Stroke Centers if they meet specific requirements. Its goal was to implement criteria to ensure that stroke patients are promptly transported and treated at hospitals with the appropriate capacity to treat acute stroke. Legislation this year will focus on ensuring hospitals participate in the Minnesota Stroke registry program so that accurate data can be compiled and used to improve service in the future.

Stroke is the 4th leading cause of death in Minnesota and contributes to about 2,000 deaths each year. It is also one of the leading causes of disability. Reducing delays in the treatment will result in preventable brain injuries. More than one-third of Minnesotans live over 60 minutes from a primary stroke center. It is imperative to have a well coordinated EMT system with designated hospitals for the treatment of stroke patients.

Simplify and Streamline Health Care Homes

Passed

Simplify and streamline Health Care Home rules to permit broader participation by patients with chronic conditions and reduce administrative overhead to providers. Reimbursement should also be standardized and increased.

It has been shown that Health Care Homes improve the quality of care for patients with chronic conditions and reduce overall costs of care. The pool of eligible patients should be expanded and the requirements to qualify as a Health Care Home simplified. Reporting should also be simplified and a single per member per month payment should be implemented.

APPENDIX

OMNIBUS HEALTH & HUMAN SERVICES POLICY BILL

CHAPTER 291

ARTICLE 2
PROVISION OF HEALTH SERVICES

Sec. 3. Minnesota Statutes 2012, section 152.126, as amended by Laws 2013, chapter 113, article 3, section 3, is amended to read:

152.126 ~~CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM~~ PRESCRIPTION MONITORING PROGRAM.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.~~(a)~~ (b) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

~~(b)~~ (c) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 5 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12. For the purposes of this section, controlled substances includes tramadol and butalbital.

~~(c)~~ (d) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30 . Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.(d) (e) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

~~(e)~~ (f) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1 or 2.

~~(f)~~ (g) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or interfere with the legitimate prescribing of controlled substances for pain. No prescriber shall be subject to disciplinary action by a health-related licensing board for prescribing a controlled substance according to the provisions of section 152.125.

Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish by January 1, 2010, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, operation, and maintenance of the electronic reporting system.

Subd. 3. **~~Prescription Electronic Reporting~~ Monitoring Program ~~Advisory Committee~~ Task Force.**

(a) The board ~~shall convene~~ shall appoint an advisory ~~committee~~. ~~The committee must include~~ task force consisting of at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a professional nursing association;

(7) a professional dental association;

(8) a consumer privacy or security advocate; ~~and~~

(9) a consumer or patient rights organization; and

(10) an association of medical examiners and coroners.

(b) The advisory ~~committee~~ task force shall advise the board on the development and operation of the ~~electronic reporting system~~ prescription monitoring program, including, but not limited to:
(1) technical standards for electronic prescription drug reporting;
(2) proper analysis and interpretation of prescription monitoring data; and
(3) an evaluation process for the program; and
(4) criteria for the unsolicited provision of prescription monitoring data by the board to prescribers and dispensers.
(c) The task force is governed by section 15.059. Notwithstanding section 15.059, subdivision 5, the task force shall not expire.
Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the following data to the board or its designated vendor, ~~subject to the notice required under paragraph (d)~~:
(1) name of the prescriber;
(2) national provider identifier of the prescriber;
(3) name of the dispenser;
(4) national provider identifier of the dispenser;
(5) prescription number;
(6) name of the patient for whom the prescription was written;
(7) address of the patient for whom the prescription was written;
(8) date of birth of the patient for whom the prescription was written;
(9) date the prescription was written;
(10) date the prescription was filled;
(11) name and strength of the controlled substance;
(12) quantity of controlled substance prescribed;
(13) quantity of controlled substance dispensed; and
(14) number of days supply.
(b) The dispenser must submit the required information by a procedure and in a format established by the board. The board may allow dispensers to omit data listed in this subdivision or may require the submission of data not listed in this subdivision provided the omission or submission is necessary for the purpose of complying with the electronic reporting or data transmission standards of the American Society for Automation in Pharmacy, the National Council on Prescription Drug Programs, or other relevant national standard-setting body.
(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:
~~(1) individuals residing in licensed skilled nursing or intermediate care facilities;~~
~~(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;~~
~~(3) individuals receiving medication intravenously;~~
~~(4) individuals receiving hospice and other palliative or end-of-life care; and~~
~~(5) individuals receiving services from a home care provider regulated under chapter 144A.~~
(1) individuals residing in a health care facility as defined in section 151.58, subdivision 2, paragraph (b), when a drug is distributed through the use of an automated drug distribution system according to section 151.58; and
(2) individuals receiving a drug sample that was packaged by a manufacturer and provided to the dispenser for dispensing as a professional sample pursuant to Code of Federal Regulations, title 21, part 203, subpart D.
(d) A dispenser must ~~not submit data under this subdivision unless~~ provide to the patient for whom the prescription was written a conspicuous notice of the reporting requirements of this section ~~is given to the patient for whom the prescription was written~~ and notice that the information may be used for program administration purposes.
Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or

dispenser in encrypted form. Except as otherwise allowed under subdivision 6, the database may be used by permissible users identified under subdivision 6 for the identification of:
(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and
(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.
(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.
(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or substantiate a disciplinary action against a prescriber.
(d) Data reported under subdivision 4 shall ~~be retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from the last day of the month during which the data was received.~~ made available to permissible users for a 12-month period beginning the day the data was received and ending 12 months from the last day of the month in which the data was received, except that permissible users defined in subdivision 6, paragraph (b), clauses (6) and (7), may use all data collected under this section for the purposes of administering, operating, and maintaining the prescription monitoring program and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program. Data retained beyond 24 months must be de-identified.
(e) The board shall not retain data reported under subdivision 4 for a period longer than four years from the date the data was received.
Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.
(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:
(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:
(i) prescribing or considering prescribing any controlled substance;
(ii) providing emergency medical treatment for which access to the data may be necessary; or
(iii) providing other medical treatment for which access to the data may be necessary and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;
(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;
(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care if the patient has consented to access to the submitted data;
~~(3)~~ (4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;
~~(4)~~ (5) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee;

~~(5)~~ (6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;
~~(6)~~ (7) authorized personnel of a vendor under contract with the ~~board~~ state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the ~~electronic reporting system~~ prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);
~~(7)~~ (8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;
~~(8)~~ (9) personnel of ~~the medical assistance program~~ Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care ~~physician~~ provider, a single outpatient pharmacy, ~~or~~ and a single hospital; ~~and~~
~~(9)~~ (10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (h); and
(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.
For purposes of clause ~~(3)~~ (4), access by an individual includes persons in the definition of an individual under section 13.02.
(c) ~~Any~~ A permissible user identified in paragraph (b), ~~who~~ clauses (1), (2), (3), (6), (7), (9), and (10) may directly ~~accesses~~ access the data electronically,. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.
(d) The board shall not release data submitted under ~~this section~~ subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.
~~(e) The board shall not release the name of a prescriber without the written consent of the prescriber or a valid search warrant or court order. The board shall provide a mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.~~
~~(f)~~ (e) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph
(c) prior to attaining direct access to the data.
~~(g)~~ (f) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.
(g) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph. The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services policy and finance on the interstate prescription monitoring program by January 5, 2016.
(h) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose

of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:
(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and
(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review. If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, part 2.34, item (c), prior to implementing this paragraph.
(i) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met. The board shall report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human ervices policy and finance on the criteria established under this paragraph and the review process by January 5, 2016. This paragraph expires August 1, 2016.
Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.
(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.
~~Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting system to determine if the system is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.~~
~~(b) The board shall submit the evaluation of the system to the legislature by July 15, 2011.~~
Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.
(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.
Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit charitable foundations, the federal government, and other sources to fund the enhancement and ongoing operations of the prescription ~~electronic reporting system~~ monitoring program established under this section. Any funds received shall be appropriated to the board for this purpose. The board may not expend funds to enhance the program in a way that conflicts with this section without seeking approval from the legislature.
(b) Notwithstanding any other section, the administrative services unit for the health-related licensing boards shall apportion between the Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of Optometry, the Board of Veterinary Medicine, and the Board of Pharmacy an amount to be paid through fees by each respective board. The amount apportioned to each board shall equal each board's share of the annual appropriation to the Board of Pharmacy from the state government special revenue fund for operating the prescription ~~electronic reporting system~~ monitoring program under this section. Each board's apportioned share shall be based on the number of prescribers or dispensers that each board identified in this paragraph licenses as a percentage of the total number of prescribers and dispensers licensed collectively by these boards. Each

respective board may adjust the fees that the boards are required to collect to compensate for the amount apportioned to each board by
the administrative services unit.

Sec. 4. **STUDY REQUIRED; PRESCRIPTION MONITORING PROGRAM DATABASE.**

(a) The Board of Pharmacy, in collaboration with the Prescription Monitoring Program Advisory Task Force, shall study the program database and report to the chairs and ranking minority members of the senate health and human services policy and finance division and the house of representatives health and human services policy and finance committees by December 15, 2014, with recommendations on: (1) requiring the use of the prescription monitoring by prescribers when prescribing or considering prescribing, and pharmacists when dispensing or considering dispensing, a controlled substance as defined in Minnesota Statutes, section 152.126, subdivision 1, paragraph (c); (2) allowing for the use of the prescription monitoring program database to identify potentially inappropriate prescribing of controlled substances; and (3) encouraging access to appropriate treatment for prescription drug abuse through the prescription monitoring program.

(b) The Board of Pharmacy, in collaboration with the prescription monitoring program advisory task force, shall conduct a study designed to assess the impact of the prescription monitoring program on the level of doctor-shopping activities and report to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction on health and human services policy and finance by December 15, 2016.

ARTICLE 4
HEALTH-RELATED LICENSING BOARDS

Sec. 2. **[146A.065] COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTICES BY LICENSED OR REGISTERED HEALTH CARE PRACTITIONERS.**

(a) A health care practitioner licensed or registered by the commissioner or a health-related licensing board, who engages in complementary and alternative health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the complementary and alternative health care practices.

(b) A health care practitioner licensed or registered by the commissioner or a health-related licensing board shall not be subject to disciplinary action solely on the basis of utilizing complementary and alternative health care practices as defined in section 146A.01, subdivision 4, paragraph (a), as a component of a patient's treatment, or for referring a patient to a complementary and alternative health care practitioner as defined in section 146A.01, subdivision 6.

(c) A health care practitioner licensed or registered by the commissioner or a health-related licensing board who utilizes complementary and alternative health care practices must provide patients receiving these services with a written copy of the complementary and alternative health care client bill of rights pursuant to section 146A.11.

(d) Nothing in this section shall be construed to prohibit or restrict the commissioner or a health-related licensing board from imposing disciplinary action for conduct that violates provisions of the applicable licensed or registered health care practitioner's practice act.

Sec. 3. Minnesota Statutes 2013 Supplement, section 146A.11, subdivision 1, is amended to read:
Subdivision 1. **Scope.** (a) All unlicensed complementary and alternative health care practitioners shall provide to each complementary and alternative health care client prior to providing treatment a written copy of the complementary and alternative health care client bill of rights. A copy must also be posted in a prominent location in the office of the unlicensed complementary and alternative health care

practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication disabilities and those who do not read or speak English. The complementary and alternative health care client bill of rights shall include the following:
(1) the name, complementary and alternative health care title, business address, and telephone number of the unlicensed complementary and alternative health care practitioner;
(2) the degrees, training, experience, or other qualifications of the practitioner regarding the complimentary and alternative health care being provided, followed by the following statement in bold print:
"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.
Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.";
(3) the name, business address, and telephone number of the practitioner's supervisor, if any;
(4) notice that a complementary and alternative health care client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints;
(5) the name, address, and telephone number of the office of unlicensed complementary and alternative health care practice and notice that a client may file complaints with the office;
(6) the practitioner's fees per unit of service, the practitioner's method of billing for such fees, the names of any insurance companies that have agreed to reimburse the practitioner, or health maintenance organizations with whom the practitioner contracts to provide service, whether the practitioner accepts Medicare, medical assistance, or general assistance medical care, and whether the practitioner is willing to accept partial payment, or to waive payment, and in what circumstances;
(7) a statement that the client has a right to reasonable notice of changes in services or charges;
(8) a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to clients;
(9) notice that the client has a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided;
(10) a statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner;
(11) a statement that client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law;
(12) a statement of the client's right to be allowed access to records and written information from records in accordance with sections 144.291 to 144.298;
(13) a statement that other services may be available in the community, including where information concerning services is available;
(14) a statement that the client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs;
(15) a statement that the client has a right to coordinated transfer when there will be a change in the provider of services;
(16) a statement that the client may refuse services or treatment, unless otherwise provided by law; and
(17) a statement that the client may assert the client's rights without retaliation.
(b) This section does not apply to an unlicensed complementary and alternative health care practitioner who is employed by or is a volunteer in a hospital or hospice who provides services to a client in a

hospital or under an appropriate hospice plan of care. Patients receiving complementary and alternative health care services in an inpatient hospital or under an appropriate hospice plan of care shall have and be made aware of the right to file a complaint with the hospital or hospice provider through which the practitioner is employed or registered as a volunteer.

(c) This section does not apply to a health care practitioner licensed or registered by the commissioner of health or a health-related licensing board who utilizes complementary and alternative health care practices within the scope of practice of the health care practitioner's professional license.

Sec. 4. Minnesota Statutes 2012, section 148.01, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of sections 148.01 to 148.10:

(1) "chiropractic~~" is defined as the science of adjusting any abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain or deranged function; and~~ means the health care discipline that recognizes the innate recuperative power of the body to heal itself without the use of drugs or surgery by identifying and caring for vertebral subluxations and other abnormal articulations by emphasizing the relationship between structure and function as coordinated by the nervous system and how that relationship affects the preservation and restoration of health;

(2) "chiropractic services" means the evaluation and facilitation of structural, biomechanical, and neurological function and integrity through the use of adjustment, manipulation, mobilization, or other procedures accomplished by manual or mechanical forces applied to bones or joints and their related soft tissues for correction of vertebral subluxation, other abnormal articulations, neurological disturbances, structural alterations, or biomechanical alterations, and includes, but is not limited to, manual therapy and mechanical therapy as defined in section 146.23;

(3) "abnormal articulation" means the condition of opposing bony joint surfaces and their related soft tissues that do not function normally, including subluxation, fixation, adhesion, degeneration, deformity, dislocation, or other pathology that results in pain or disturbances within the nervous system, results in postural alteration, inhibits motion, allows excessive motion, alters direction of motion, or results in loss of axial loading efficiency, or a combination of these;

(4) "diagnosis" means the physical, clinical, and laboratory examination of the patient, and the use of diagnostic services for diagnostic purposes within the scope of the practice of chiropractic described in sections 148.01 to 148.10;

(5) "diagnostic services" means clinical, physical, laboratory, and other diagnostic measures, including diagnostic imaging that may be necessary to determine the presence or absence of a condition, deficiency, deformity, abnormality, or disease as a basis for evaluation of a health concern, diagnosis, differential diagnosis, treatment, further examination, or referral;

(6) "therapeutic services" means rehabilitative therapy as defined in Minnesota Rules, part 2500.0100, subpart 11, and all of the therapeutic, rehabilitative, and preventive sciences and procedures for which the licensee was subject to examination under section 148.06. When provided, therapeutic services must be performed within a practice where the primary focus is the provision of chiropractic services, to prepare the patient for chiropractic services, or to complement the provision of chiropractic services. The administration of therapeutic services is the responsibility of the treating chiropractor and must be rendered under the direct supervision of qualified staff;

(7) "acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment. Acupuncture may not be used as an independent therapy or separately from chiropractic services. Acupuncture is permitted under section 148.01 only after registration with the board which requires completion of a board-approved course of study and successful completion of a board-approved national examination on acupuncture. Renewal of registration shall require completion of board-approved continuing education requirements in acupuncture. The restrictions of section 147B.02, subdivision 2, apply to individuals registered to perform acupuncture under this section; and

~~(2)~~ (8) "animal chiropractic diagnosis and treatment" means treatment that includes identifying and resolving vertebral subluxation complexes, spinal manipulation, and manipulation of the extremity articulations of nonhuman vertebrates. Animal chiropractic diagnosis and treatment does not include:
(i) performing surgery;
(ii) dispensing or administering of medications; or
(iii) performing traditional veterinary care and diagnosis.

Sec. 5. Minnesota Statutes 2012, section 148.01, subdivision 2, is amended to read:
Subd. 2. **Exclusions.** The practice of chiropractic is not the practice of medicine, surgery, or osteopathy, or physical therapy.

Sec. 6. Minnesota Statutes 2012, section 148.01, is amended by adding a subdivision to read:
Subd. 4. **Practice of chiropractic.** An individual licensed to practice under section 148.06 is authorized to perform chiropractic services, acupuncture, and therapeutic services, and to provide diagnosis and to render opinions pertaining to those services for the purpose of determining a course of action in the best interests of the patient, such as a treatment plan, appropriate referral, or both.

Sec. 8. Minnesota Statutes 2012, section 148.261, is amended by adding a subdivision to read:
Subd. 1a. **Conviction of a felony-level criminal sexual offense.** (a) Except as provided in paragraph (e), the board may not grant or renew a license to practice nursing to any person who has been convicted on or after August 1, 2014, of any of the provisions of sections 609.342, subdivision 1, 609.343, subdivision 1, 609.344, subdivision 1, paragraphs (c) to (o), or 609.345, subdivision 1, paragraphs (c) to (o), or a similar statute in another jurisdiction.
(b) A license to practice nursing is automatically revoked if the licensee is convicted of an offense listed in paragraph (a).
(c) A license to practice nursing that has been denied or revoked under this subdivision is not subject to chapter 364.
(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.
(e) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become licensed provided that the criteria:
(1) utilize a rebuttable presumption that the applicant is not suitable for licensing;
(2) provide a standard for overcoming the presumption; and
(3) require that a minimum of ten years has elapsed since the applicant's sentence was discharged.
The board shall not consider an application under this paragraph if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

Sec. 9. Minnesota Statutes 2012, section 148.261, subdivision 4, is amended to read:
Subd. 4. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, clause (3) or (4), or subdivision 1a, a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of the violation concerned.

Sec. 10. Minnesota Statutes 2012, section 148.6402, subdivision 17, is amended to read:
Subd. 17. **Physical agent modalities.** "Physical agent modalities" mean modalities that use the properties of light, water, temperature, sound, or electricity to produce a response in soft tissue. ~~The physical agent modalities referred to in sections 148.6404 and 148.6440 are superficial physical agent modalities, electrical stimulation devices, and ultrasound.~~
EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. Minnesota Statutes 2012, section 148.7802, subdivision 3, is amended to read:
Subd. 3. **Approved education program.** "Approved education program" means a university, college, or other postsecondary education program of athletic training that, at the time the student completes the program, is approved or accredited by ~~the National Athletic Trainers Association Professional Education Committee, the National Athletic Trainers Association Board of Certification, or the Joint Review Committee on Educational Programs in Athletic Training in collaboration with the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Association, and the National Athletic Trainers Association~~ a nationally recognized accreditation agency for athletic training education programs approved by the board.

Sec. 15. Minnesota Statutes 2012, section 148.7802, subdivision 9, is amended to read:
Subd. 9. **Credentialing examination.** "Credentialing examination" means an examination administered by the ~~National Athletic Trainers Association~~ Board of Certification, or the board's recognized successor, for credentialing as an athletic trainer, or an examination for credentialing offered by a national testing service that is approved by the board.

Sec. 16. Minnesota Statutes 2012, section 148.7803, subdivision 1, is amended to read:
Subdivision 1. **Designation.** A person shall not use in connection with the person's name the words or letters registered athletic trainer; licensed athletic trainer; Minnesota registered athletic trainer; athletic trainer; AT; ATR; or any words, letters, abbreviations, or insignia indicating or implying that the person is an athletic trainer, without a certificate of registration as an athletic trainer issued under sections 148.7808 to 148.7810. A student attending a college or university athletic training program must be identified as ~~a "student athletic trainer."~~ an "athletic training student."

Sec. 17. Minnesota Statutes 2012, section 148.7805, subdivision 1, is amended to read:
Subdivision 1. ~~**Creation;**~~ **Membership.** The Athletic Trainers Advisory Council is created and is composed of eight members appointed by the board. The advisory council consists of:
(1) two public members as defined in section 214.02;
(2) three members who~~, except for initial appointees,~~ are registered athletic trainers, one being both a licensed physical therapist and registered athletic trainer as submitted by the Minnesota American Physical Therapy Association;
(3) two members who are medical physicians licensed by the state and have experience with athletic training and sports medicine; and
(4) one member who is a doctor of chiropractic licensed by the state and has experience with athletic training and sports injuries.

Sec. 18. Minnesota Statutes 2012, section 148.7808, subdivision 1, is amended to read:
Subdivision 1. **Registration.** The board may issue a certificate of registration as an athletic trainer to applicants who meet the requirements under this section. An applicant for registration as an athletic trainer shall pay a fee under section 148.7815 and file a written application on a form, provided by the board, that includes:
(1) the applicant's name, Social Security number, home address and telephone number, business address and telephone number, and business setting;
(2) evidence satisfactory to the board of the successful completion of an education program approved by the board;
(3) educational background;
(4) proof of a baccalaureate or master's degree from an accredited college or university;
(5) credentials held in other jurisdictions;
(6) a description of any other jurisdiction's refusal to credential the applicant;
(7) a description of all professional disciplinary actions initiated against the applicant in any other

jurisdiction;
(8) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
(9) evidence satisfactory to the board of a qualifying score on a credentialing examination ~~within one year of the application for registration~~;
(10) additional information as requested by the board;
(11) the applicant's signature on a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
(12) the applicant's signature on a waiver authorizing the board to obtain access to the applicant's records in this state or any other state in which the applicant has completed an education program approved by the board or engaged in the practice of athletic training.

Sec. 19. Minnesota Statutes 2012, section 148.7808, subdivision 4, is amended to read:
Subd. 4. **Temporary registration.** (a) The board may issue a temporary registration as an athletic trainer to qualified applicants. A temporary registration is issued for ~~one year~~ 120 days. An athletic trainer with a temporary registration may qualify for full registration after submission of verified documentation that the athletic trainer has achieved a qualifying score on a credentialing examination within ~~one year~~ 120 days after the date of the temporary registration. A temporary registration may not be renewed.
(b) Except as provided in subdivision 3, paragraph (a), clause (1), an applicant for a temporary registration must submit the application materials and fees for registration required under subdivision 1, clauses (1) to (8) and (10) to (12).
(c) An athletic trainer with a temporary registration shall work only under the direct supervision of an athletic trainer registered under this section. No more than ~~four~~ two athletic trainers with temporary registrations shall work under the direction of a registered athletic trainer.

Sec. 20. Minnesota Statutes 2012, section 148.7812, subdivision 2, is amended to read:
Subd. 2. **Approved programs.** The board shall approve a continuing education program that has been approved for continuing education credit by the ~~National Athletic Trainers Association~~ Board of Certification, or the board's recognized successor.

Sec. 21. Minnesota Statutes 2012, section 148.7813, is amended by adding a subdivision to read:
Subd. 5. **Discipline; reporting.** For the purposes of this chapter, registered athletic trainers and applicants are subject to sections 147.091 to 147.162.

Sec. 22. Minnesota Statutes 2012, section 148.7814, is amended to read:
148.7814 APPLICABILITY.
Sections 148.7801 to 148.7815 do not apply to persons who are certified as athletic trainers by the ~~National Athletic Trainers Association~~ Board of Certification or the board's recognized successor and come into Minnesota for a specific athletic event or series of athletic events with an individual or group.

Sec. 46. **[214.077] TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF HARM.**
(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe continued practice by the regulated person presents an imminent risk of harm, the licensing board shall temporarily suspend the regulated person's professional license. The suspension shall take effect upon written notice to the regulated person and shall specify the reason for the suspension.
(b) The suspension shall remain in effect until the appropriate licensing board or the commissioner completes an investigation and issues a final order in the matter after a hearing.
(c) At the time it issues the suspension notice, the appropriate licensing board shall schedule a disciplinary hearing to be held before the licensing board or pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any hearing held pursuant to

this subdivision. The hearing shall be scheduled to begin no later than 30 days after issuance of the suspension order.
(d) If the board has not completed its investigation and issued a final order within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 47. Minnesota Statutes 2012, section 214.09, subdivision 3, is amended to read:
Subd. 3. **Compensation.** (a) ~~Members of the boards may be compensated at the rate of $55 a day spent on board activities, when authorized by the board, plus expenses in~~ Members of health-related licensing boards may be compensated at the rate of $75 a day spent on board activities and members of nonhealth-related licensing boards may be compensated at the rate of $55 a day spent on board activities when authorized by the board, plus expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred, may be reimbursed for those expenses upon board authorization.
(b) Members who are state employees or employees of the political subdivisions of the state must not receive the daily payment for activities that occur during working hours for which they are also compensated by the state or political subdivision. However, a state or political subdivision employee may receive the daily payment if the employee uses vacation time or compensatory time accumulated in accordance with a collective bargaining agreement or compensation plan for board activity. Members who are state employees or employees of the political subdivisions of the state may receive the expenses provided for in this subdivision unless the expenses are reimbursed by another source. Members who are state employees or employees of political subdivisions of the state may be reimbursed for child care expenses only for time spent on board activities that are outside their working hours.
(c) Each board must adopt internal standards prescribing what constitutes a day spent on board activities for purposes of making daily payments under this subdivision.

Sec. 48. Minnesota Statutes 2012, section 214.103, subdivision 2, is amended to read:
Subd. 2. **Receipt of complaint.** The boards shall receive and resolve complaints or other communications, whether oral or written, against regulated persons. Before resolving an oral complaint, the executive director or a board member designated by the board to review complaints shall require the complainant to state the complaint in writing or authorize transcribing the complaint. The executive director or the designated board member shall determine whether the complaint alleges or implies a violation of a statute or rule which the board is empowered to enforce. The executive director or the designated board member may consult with the designee of the attorney general as to a board's jurisdiction over a complaint. If the executive director or the designated board member determines that it is necessary, the executive director may seek additional information to determine whether the complaint is jurisdictional or to clarify the nature of the allegations by obtaining records or other written material, obtaining a handwriting sample from the regulated person, clarifying the alleged facts with the complainant, and requesting a written response from the subject of the complaint. The executive director may authorize a field investigation to clarify the nature of the allegations and the facts that led to the complaint.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 49. Minnesota Statutes 2012, section 214.103, subdivision 3, is amended to read:
Subd. 3. **Referral to other agencies.** The executive director shall forward to another governmental agency any complaints received by the board which do not relate to the board's jurisdiction but which relate to matters within the jurisdiction of another governmental agency. The agency shall advise the executive director of the disposition of the complaint. A complaint or other information received by

another governmental agency relating to a statute or rule which a board is empowered to enforce must be forwarded to the executive director of the board to be processed in accordance with this section. Governmental agencies ~~may~~ shall coordinate and conduct joint investigations of complaints that involve more than one governmental agency.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 50. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision to read:
Subd. 5. **Health professionals services program.** The health-related licensing boards shall include information regarding the health professionals services program on their Web sites.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 51. Minnesota Statutes 2012, section 214.29, is amended to read:
214.29 PROGRAM REQUIRED.
Notwithstanding section 214.28, each health-related licensing board, including the Emergency Medical Services Regulatory Board under chapter 144E, shall ~~either conduct a~~ contract with the health professionals service program under sections 214.31 to 214.37 ~~or contract for a diversion program under section 214.28~~ for a diversion program for regulated professionals who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition.
EFFECTIVE DATE. This section is effective July 1, 2014, and sunsets July 1, 2015.

Sec. 52. Minnesota Statutes 2012, section 214.31, is amended to read:
214.31 AUTHORITY.
~~Two or more of the health-related licensing boards listed in section 214.01, subdivision 2, may jointly~~ Notwithstanding section 214.36, the health professionals services program shall contract with the health-related licensing boards to conduct a health professionals services program to protect the public from persons regulated by the boards who are unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition. The program does not affect a board's authority to discipline violations of a board's practice act. For purposes of sections 214.31 to 214.37, the emergency medical services regulatory board shall be included in the definition of a health-related licensing board under chapter 144E.
EFFECTIVE DATE. This section is effective July 1, 2014, and sunsets July 1, 2015.

Sec. 53. Minnesota Statutes 2012, section 214.32, is amended by adding a subdivision to read:
Subd. 6. **Duties of a participating board.** Upon receiving a report from the program manager in accordance with section 214.33, subdivision 3, that a regulated person has been discharged from the program due to noncompliance based on allegations that the regulated person has engaged in conduct that might cause risk to the public, when the participating board has probable cause to believe continued practice by the regulated person presents an imminent risk of harm, the board shall temporarily suspend the regulated person's professional license until the completion of a disciplinary investigation. The board must complete the disciplinary investigation within 30 days of receipt of the report from the program. If the investigation is not completed by the board within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation.

Sec. 54. Minnesota Statutes 2012, section 214.33, subdivision 3, is amended to read:
Subd. 3. **Program manager.** (a) The program manager shall report to the appropriate participating board a regulated person who:
(1) does not meet program admission criteria,;
(2) violates the terms of the program participation agreement, or;

(3) leaves or is discharged from the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement.;
(4) is subject to the provisions of sections 214.17 to 214.25;
(5) causes identifiable patient harm;
(6) unlawfully substitutes or adulterates medications;
(7) writes a prescription or causes a prescription to be dispensed in the name of a person, other than the prescriber, or veterinary patient for the personal use of the prescriber;
(8) alters a prescription without the knowledge of the prescriber for the purpose of obtaining a drug for personal use;
(9) unlawfully uses a controlled or mood-altering substance or uses alcohol while providing patient care or during the period of time in which the regulated person may be contacted to provide patient care or is otherwise on duty, if current use is the reason for participation in the program or the use occurs while the regulated person is participating in the program; or
~~The program manager shall report to the appropriate participating board a regulated person who~~ (10) is alleged to have committed violations of the person's practice act that are outside the authority of the health professionals services program as described in sections 214.31 to 214.37.
(b) The program manager shall inform any reporting person of the disposition of the person's report to the program.
EFFECTIVE DATE. This section is effective August 1, 2014, and applies to violations that occur after the effective date.

Sec. 55. Minnesota Statutes 2012, section 214.33, is amended by adding a subdivision to read:
Subd. 5. **Employer mandatory reporting.** (a) An employer of a person regulated by a health-related licensing board, and a health care institution or other organization where the regulated person is engaged in providing services, must report to the appropriate licensing board that a regulated person has diverted narcotics or other controlled substances in violation of state or federal narcotics or controlled substance law if:
(1) the employer, health care institution, or organization making the report has knowledge of the diversion; and
(2) the regulated person has diverted narcotics or other controlled substances from the reporting employer, health care institution, or organization, or at the reporting institution or organization.
(b) The requirement to report under this subdivision does not apply if:
(1) the regulated person is self-employed;
(2) the knowledge was obtained in the course of a professional-patient relationship and the regulated person is the patient; or
(3) knowledge of the diversion first becomes known to the employer, health care institution, or other organization, either from (i) an individual who is serving as a work site monitor approved by the health professional services program for the regulated person who has self-reported to the health professional services program, and who has returned to work pursuant to a health professional services program participation agreement and monitoring plan; or (ii) the regulated person who has self-reported to the health professional services program and who has returned to work pursuant to the health professional services program participation agreement and monitoring plan.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 56. **[214.355] GROUNDS FOR DISCIPLINARY ACTION.**
Each health-related licensing board, including the Emergency Medical Services Regulatory Board under chapter 144E, shall consider it grounds for disciplinary action if a regulated person violates the terms of the health professionals services program participation agreement or leaves the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement.
EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 57. Minnesota Statutes 2013 Supplement, section 364.09, is amended to read:

364.09 EXCEPTIONS.

(a) This chapter does not apply to the licensing process for peace officers; to law enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire protection agencies; to eligibility for a private detective or protective agent license; to the licensing and background study process under chapters 245A and 245C; to eligibility for school bus driver endorsements; to eligibility for special transportation service endorsements; to eligibility for a commercial driver training instructor license, which is governed by section 171.35 and rules adopted under that section; to emergency medical services personnel, or to the licensing by political subdivisions of taxicab drivers, if the applicant for the license has been discharged from sentence for a conviction within the ten years immediately preceding application of a violation of any of the following:

(1) sections 609.185 to 609.21, 609.221 to 609.223, 609.342 to 609.3451, or 617.23, subdivision 2 or 3;

(2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years or more; or

(3) a violation of chapter 169 or 169A involving driving under the influence, leaving the scene of an accident, or reckless or careless driving. This chapter also shall not apply to eligibility for juvenile corrections employment, where the offense involved child physical or sexual abuse or criminal sexual conduct.

(b) This chapter does not apply to a school district or to eligibility for a license issued or renewed by the Board of Teaching or the commissioner of education.

(c) Nothing in this section precludes the Minnesota Police and Peace Officers Training Board or the state fire marshal from recommending policies set forth in this chapter to the attorney general for adoption in the attorney general's discretion to apply to law enforcement or fire protection agencies.

(d) This chapter does not apply to a license to practice medicine that has been denied or revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.

(e) This chapter does not apply to any person who has been denied a license to practice chiropractic or whose license to practice chiropractic has been revoked by the board in accordance with section 148.10, subdivision 7.

(f) This chapter does not apply to any license, registration, or permit that has been denied or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.

~~(f)~~ (g) This chapter does not supersede a requirement under law to conduct a criminal history background investigation or consider criminal history records in hiring for particular types of employment.

ARTICLE 5
BOARD OF PHARMACY

Section 1. Minnesota Statutes 2012, section 151.01, is amended to read:

151.01 DEFINITIONS.

Subd. 35. **Compounding.** "Compounding" means preparing, mixing, assembling, packaging, and labeling a drug for an identified individual patient as a result of a practitioner's prescription drug order. Compounding also includes anticipatory compounding, as defined in this section, and the preparation of drugs in which all bulk drug substances and components are nonprescription substances. Compounding does not include mixing or reconstituting a drug according to the product's labeling or to the manufacturer's directions. Compounding does not include the preparation of a drug for the purpose of, or incident to, research, teaching, or chemical analysis, provided that the drug is not prepared for dispensing or administration to patients. All compounding, regardless of the type of product, must be done pursuant to a prescription drug order unless otherwise permitted in this chapter or by the rules of the board. Compounding does not include a minor deviation from such directions with regard to radioactivity, volume, or stability, which is made by or under the supervision of a licensed nuclear pharmacist or a

physician, and which is necessary in order to accommodate circumstances not contemplated in the manufacturer's instructions, such as the rate of radioactive decay or geographical distance from the patient.

Subd. 36. **Anticipatory compounding.** "Anticipatory compounding" means the preparation by a pharmacy of a supply of a compounded drug product that is sufficient to meet the short-term anticipated need of the pharmacy for the filling of prescription drug orders. In the case of practitioners only, anticipatory compounding means the preparation of a supply of a compounded drug product that is sufficient to meet the practitioner's short-term anticipated need for dispensing or administering the drug to patients treated by the practitioner. Anticipatory compounding is not the preparation of a compounded drug product for wholesale distribution.

Subd. 37. **Extemporaneous compounding.** "Extemporaneous compounding" means the compounding of a drug product pursuant to a prescription drug order for a specific patient that is issued in advance of the compounding. Extemporaneous compounding is not the preparation of a compounded drug product for wholesale distribution.

Subd. 38. **Compounded positron emission tomography drug.** "Compounded positron emission tomography drug" means a drug that:

(1) exhibits spontaneous disintegration of unstable nuclei by the emission of positrons and is used for the purpose of providing dual photon positron emission tomographic diagnostic images;

(2) has been compounded by or on the order of a practitioner in accordance with the relevant parts of Minnesota Rules, chapters 4731 and 6800, for a patient or for research, teaching, or quality control; and

(3) includes any nonradioactive reagent, reagent kit, ingredient, nuclide generator, accelerator, target material, electronic synthesizer, or other apparatus or computer program to be used in the preparation of such a drug.

Sec. 9. **[151.251] COMPOUNDING.**

Subdivision 1. **Exemption from manufacturing licensure requirement.** Section 151.252 shall not apply to:

(1) a practitioner engaged in extemporaneous compounding, anticipatory compounding, or compounding not done pursuant to a prescription drug order when permitted by this chapter or the rules of the board; and

(2) a pharmacy in which a pharmacist is engaged in extemporaneous compounding, anticipatory compounding, or compounding not done pursuant to a prescription drug order when permitted by this chapter or the rules of the board.

Subd. 2. **Compounded drug.** A drug product may be compounded under this section if a pharmacist or practitioner:

(1) compounds the drug product using bulk drug substances, as defined in the federal regulations published in Code of Federal Regulations, title 21, section 207.3(a)(4):

(i) that:

(A) comply with the standards of an applicable United States Pharmacopoeia or National Formulary monograph, if a monograph exists, and the United States Pharmacopoeia chapter on pharmacy compounding;

(B) if such a monograph does not exist, are drug substances that are components of drugs approved for use in this country by the United States Food and Drug Administration; or

(C) if such a monograph does not exist and the drug substance is not a component of a drug approved for use in this country by the United States Food and Drug Administration, that appear on a list developed by the United States Food and Drug Administration through regulations issued by the secretary of the federal Department of Health and Human Services pursuant to section 503A of the Food, Drug and Cosmetic Act under paragraph (d);

(ii) that are manufactured by an establishment that is registered under section 360 of the federal Food, Drug and Cosmetic Act, including a foreign establishment that is registered under section 360(i) of that act; and

(iii) that are accompanied by valid certificates of analysis for each bulk drug substance;
(2) compounds the drug product using ingredients, other than bulk drug substances, that comply with the standards of an applicable United States Pharmacopoeia or National Formulary monograph, if a monograph exists, and the United States Pharmacopoeia chapters on pharmacy compounding;
(3) does not compound a drug product that appears on a list published by the secretary of the federal Department of Health and Human Services in the Federal Register of drug products that have been withdrawn or removed from the market because such drug products or components of such drug products have been found to be unsafe or not effective;
(4) does not compound any drug products that are essentially copies of a commercially available drug product; and
(5) does not compound any drug product that has been identified pursuant to United States Code, title 21, section 353a, as a drug product that presents demonstrable difficulties for compounding that reasonably demonstrate an adverse effect on the safety or effectiveness of that drug product.
The term "essentially a copy of a commercially available drug product" does not include a drug product in which there is a change, made for an identified individual patient, that produces for that patient a significant difference, as determined by the prescribing practitioner, between the compounded drug and the comparable commercially available drug product.
Subd. 3. **Exceptions.** This section shall not apply to:
(1) compounded positron emission tomography drugs as defined in section 151.01, subdivision 38; or
(2) radiopharmaceuticals.

Sec. 10. Minnesota Statutes 2013 Supplement, section 151.252, is amended by adding a subdivision to read:
Subd. 1a. **Outsourcing facility.** (a) No person shall act as an outsourcing facility without first obtaining a license from the board and paying any applicable manufacturer licensing fee specified in section 151.065.
(b) Application for an outsourcing facility license under this section shall be made in a manner specified by the board and may differ from the application required of other drug manufacturers.
(c) No license shall be issued or renewed for an outsourcing facility unless the applicant agrees to operate in a manner prescribed for outsourcing facilities by federal and state law and according to Minnesota Rules.
(d) No license shall be issued or renewed for an outsourcing facility unless the applicant supplies the board with proof of such registration by the United States Food and Drug Administration as required by United States Code, title 21, section 353b.
(e) No license shall be issued or renewed for an outsourcing facility that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration. The board may establish, by rule, standards for the licensure of an outsourcing facility that is not required to be licensed or registered by the state in which it is physically located.
(f) The board shall require a separate license for each outsourcing facility located within the state and for each outsourcing facility located outside of the state at which drugs that are shipped into the state are prepared.
(g) The board shall not issue an initial or renewed license for an outsourcing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of an outsourcing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

ARTICLE 6
HEALTH DEPARTMENT AND PUBLIC HEALTH

Section 1. Minnesota Statutes 2012, section 62J.497, subdivision 5, is amended to read:
Subd. 5. **Electronic drug prior authorization standardization and transmission.**
(a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.
(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.
(c) No later than January 1, ~~2015~~ 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

Sec. 2. **[144.1212] NOTICE TO PATIENT; MAMMOGRAM RESULTS.**
Subdivision 1. **Definition.** For purposes of this section, "facility" has the meaning provided in United States Code, title 42, section 263b(a)(3)(A).
Subd. 2. **Required notice.** A facility at which a mammography examination is performed shall, if a patient is categorized by the facility as having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology, include in the summary of the written report that is sent to the patient, as required by the federal Mammography Quality Standards Act, United States Code, title 42, section 263b, notice that the patient has dense breast tissue, that this may make it more difficult to detect cancer on a mammogram, and that it may increase her risk of breast cancer. The following language may be used:
"Your mammogram shows that your breast tissue is dense. Dense breast tissue is relatively common and is found in more than 40 percent of women. However, dense breast tissue may make it more difficult to identify precancerous lesions or cancer through a mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your own awareness and to help inform your conversations with your treating clinician who has received a report of your mammogram results. Together you can decide which screening options are right for you based on your mammogram results, individual risk factors, or physical examination."

Sec. 3. Minnesota Statutes 2013 Supplement, section 144.1225, subdivision 2, is amended to read:
Subd. 2. **Accreditation required.** (a)(1) Except as otherwise provided in ~~paragraph~~ paragraphs (b) and (c), advanced diagnostic imaging services eligible for reimbursement from any source, including, but not limited to, the individual receiving such services and any individual or group insurance contract, plan, or policy delivered in this state, including, but not limited to, private health insurance plans, workers' compensation insurance, motor vehicle insurance, the State Employee Group Insurance Program (SEGIP), and other state health care programs, shall be reimbursed only if the facility at which the service has been conducted and processed is licensed pursuant to sections 144.50 to 144.56 or accredited by one of the following entities:
(i) American College of Radiology (ACR);

(ii) Intersocietal Accreditation Commission (IAC);
(iii) the Joint Commission; or
(iv) other relevant accreditation organization designated by the Secretary of the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1395M.
(2) All accreditation standards recognized under this section must include, but are not limited to:
(i) provisions establishing qualifications of the physician;
(ii) standards for quality control and routine performance monitoring by a medical physicist;
(iii) qualifications of the technologist, including minimum standards of supervised clinical experience;
(iv) guidelines for personnel and patient safety; and
(v) standards for initial and ongoing quality control using clinical image review and quantitative testing.
(b) Any facility that performs advanced diagnostic imaging services and is eligible to receive reimbursement for such services from any source in paragraph (a), clause (1), must obtain licensure pursuant to sections 144.50 to 144.56 or accreditation pursuant to paragraph (a) by August 1, 2013. Thereafter, all facilities that provide advanced diagnostic imaging services in the state must obtain licensure or accreditation ~~prior to~~ within six months of commencing operations and must~~, at all times,~~ maintain either licensure pursuant to sections 144.50 to 144.56 or accreditation with an accrediting organization as provided in paragraph (a).
(c) Dental clinics or offices that perform diagnostic imaging through dental cone beam computerized tomography do not need to meet the accreditation or reporting requirements in this section.
EFFECTIVE DATE. The amendment to paragraph (b) is effective the day following final enactment. The amendment to paragraph (a) and paragraph (c) are effective retroactively from August 1, 2013.

Sec. 5. Minnesota Statutes 2012, section 144.414, subdivision 3, is amended to read:
Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.
(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well-ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.
(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

Sec. 6. Minnesota Statutes 2012, section 144.414, is amended by adding a subdivision to read:
Subd. 5. **Electronic cigarettes.** (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:
(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;
(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;
(3) any facility licensed by the commissioner of human services; or
(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.
(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

Sec. 8. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a comprehensive stroke center if the hospital has been certified as a comprehensive stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Sec. 9. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 2, is amended to read:

Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke center if the hospital has been certified as a primary stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Sec. 24. Minnesota Statutes 2012, section 325H.05, is amended to read:

325H.05 POSTED WARNING REQUIRED.

(a) The facility owner or operator shall conspicuously post the warning ~~sign~~ signs described in ~~paragraph~~ paragraphs (b) and (c) within three feet of each tanning station.

The sign must be clearly visible, not obstructed by any barrier, equipment, or other object, and must be posted so that it can be easily viewed by the consumer before energizing the tanning equipment.

(b) The warning sign required in paragraph (a) shall have dimensions not less than eight inches by ten inches, and must have the following wording:

"DANGER - ULTRAVIOLET RADIATION

-Follow instructions.

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

-Wear protective eyewear.

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

-Medications or cosmetics may increase your sensitivity to the ultraviolet radiation.

Consult a physician before using sunlamp or tanning equipment if you are using medications or have a history of skin problems or believe yourself to be especially sensitive to sunlight."

(c) All tanning facilities must prominently display a sign in a conspicuous place, at the point of sale, that states it is unlawful for a tanning facility or operator to allow a person under age 18 to use any tanning equipment.

Sec. 25. **[325H.085] USE BY MINORS PROHIBITED.**

A person under age 18 may not use any type of tanning equipment as defined by section 325H.01, subdivision 6, available in a tanning facility in this state.

Sec. 26. Minnesota Statutes 2012, section 325H.09, is amended to read:

325H.09 PENALTY.

Any person who leases tanning equipment or who owns a tanning facility and who operates or permits the equipment or facility to be operated in noncompliance with the requirements of sections 325H.01 to ~~325H.08~~ 325H.085 is guilty of a petty misdemeanor.

ARTICLE 9
HEALTH CARE

Sec. 4. **DIRECTION TO COMMISSIONER; STRATEGIES TO ADDRESS CHRONIC CONDITIONS.**
The commissioner of human services shall incorporate strategies and activities in the Department of Human Service's planning efforts and design of the state Medicaid plan option under section 2703 of the Patient Protection and Affordable Care Act that address chronic medical or behavioral health conditions complicated by socioeconomic factors such as race, ethnicity, age, immigration, or language.

ADVANCED PRACTICE REGISTERED NURSE

Section 1. Minnesota Statutes 2012, section 148.171, subdivision 3, is amended to read:
Subd. 3. **Advanced practice registered nurse.** "Advanced practice registered nurse," abbreviated APRN, means an individual licensed as ~~a~~ an advanced practice registered nurse by the board and certified by a national nurse certification organization acceptable to the board to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner. The national nursing certification organization must:
(1) be endorsed by a national professional nursing organization that describes scope and standards statements specific to the practice as a clinical nurse specialist, nurse-midwife, nurse practitioner, or registered nurse anesthetist for the population focus for which the individual will be certified;
(2) be independent from the national professional nursing organization in decision-making for all matters pertaining to certification or recertification;
(3) administer a professional nursing certification program that is psychometrically sound and legally defensible, and meets nationally recognized accreditation standards for certification programs; and
(4) require periodic recertification or be affiliated with an organization that provides recertification.

Sec. 2. Minnesota Statutes 2012, section 148.171, is amended by adding a subdivision to read:
Subd. 4a. **Certification.** "Certification" means the formal recognition of knowledge, skills, and experience demonstrated by the achievement of standards identified by the National Professional Nursing Organization acceptable to the Minnesota Board of Nursing.

Sec. 3. Minnesota Statutes 2012, section 148.171, subdivision 5, is amended to read:
Subd. 5. **Clinical nurse specialist practice.** "Clinical nurse specialist practice" means ~~the provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing within the context of collaborative management, and includes: (1) diagnosing illness and disease; (2) providing nonpharmacologic treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The~~

~~certified clinical nurse specialist is certified for advanced practice registered nursing in a specific field of clinical nurse specialist practice.~~:
(1) the diagnosis and treatment of health and illness states;
(2) disease management;
(3) prescribing pharmacologic and nonpharmacologic therapies;
(4) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) prevention of illness and risk behaviors;
(6) nursing care for individuals, families, and communities;
(7) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient; and
(8) integration of care across the continuum to improve patient outcomes.

Sec. 4. Minnesota Statutes 2012, section 148.171, is amended by adding a subdivision to read:
Subd. 6a. **Collaboration.** "Collaboration" means the process in which two or more health care professionals work together to meet the health care needs of a patient, as warranted by the patient.

Sec. 5. Minnesota Statutes 2012, section 148.171, subdivision 9, is amended to read:
Subd. 9. **Nurse.** "Nurse" means advanced practice registered nurse, registered nurse, ~~advanced practice registered nurse,~~ and licensed practical nurse unless the context clearly refers to only one category.

Sec. 6. Minnesota Statutes 2012, section 148.171, subdivision 10, is amended to read:
Subd. 10. **Nurse-midwife practice.** "Nurse-midwife practice" means ~~the management of women's primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women and includes diagnosing and providing nonpharmacologic treatment within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.~~:
(1) the management, diagnosis, and treatment of women's primary health care including pregnancy, childbirth, postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women across the life span;
(2) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(3) prescribing pharmacologic and nonpharmacologic therapies; and
(4) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

Sec. 7. Minnesota Statutes 2012, section 148.171, subdivision 11, is amended to read:
Subd. 11. **Nurse practitioner practice.** "Nurse practitioner practice" means~~,~~ ~~within the context of collaborative management: (1) diagnosing, directly managing, and~~

~~preventing acute and chronic illness and disease; and (2) promoting wellness, including providing nonpharmacologic treatment. The certified nurse practitioner is certified for advanced registered nurse practice in a specific field of nurse practitioner practice.~~ the provision of care including:
(1) health promotion, disease prevention, health education, and counseling;
(2) providing health assessment and screening activities;
(3) diagnosing, treating, and facilitating patients' management of their acute and chronic illnesses and diseases;
(4) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) prescribing pharmacologic and nonpharmacologic therapies; and
(6) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

Sec. 8. Minnesota Statutes 2012, section 148.171, is amended by adding a subdivision to read:
Subd. 12a. **Population focus.** "Population focus" means the categories of patients for which the advanced practice registered nurse has the educational preparation to provide care and services. The categories of population foci are:
(1) family and individual across the life span;
(2) adult gerontology;
(3) neonatal;
(4) pediatrics;
(5) women's and gender-related health; and
(6) psychiatric and mental health.

Sec. 9. Minnesota Statutes 2012, section 148.171, subdivision 13, is amended to read:
Subd. 13. **Practice of advanced practice registered nursing.** (a) The "practice of advanced practice registered nursing" means the performance of ~~clinical nurse specialist practice, nurse-midwife practice, nurse practitioner practice, or registered nurse anesthetist practice as defined in subdivisions 5, 10, 11, and 21~~ an expanded scope of nursing in at least one of the recognized advanced practice registered nurse roles for at least one population focus. The scope and practice standards of an advanced practice registered nurse are defined by the national professional nursing organizations specific to the practice as a clinical nurse specialist, nurse-midwife, nurse practitioner, or registered nurse anesthetist in the population focus. The scope of advanced practice registered nursing includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering. The practice includes functioning as a primary care provider, direct care provider, case manager, consultant, educator, and researcher. ~~The practice of advanced practice registered nursing also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers, including but not limited to physicians, chiropractors, podiatrists, and dentists, provided that the advanced practice registered nurse and the other provider are practicing within their scopes of practice as defined in state law. The advanced practice registered nurse must practice within a health care system that provides for consultation, collaborative~~

~~management, and referral as indicated by the health status of the patient.~~
(b) The practice of advanced practice registered nursing requires the advanced practice registered nurse to be accountable: (1) to patients for the quality of advanced nursing care rendered; (2) for recognizing limits of knowledge and experience; and (3) for planning for the management of situations beyond the advanced practice registered nurse's expertise. The practice of advanced practice registered nursing includes accepting referrals from, consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

Sec. 10. Minnesota Statutes 2012, section 148.171, subdivision 16, is amended to read:
Subd. 16. **Prescribing.** "Prescribing" means the act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device in accordance with the provisions of section 148.235. Prescribing does not include recommending the use of a drug or therapeutic device which is not required by the federal Food and Drug Administration to meet the labeling requirements for prescription drugs and devices. Prescribing also does not include recommending or administering a drug or therapeutic device ~~perioperatively~~ for anesthesia care by a certified registered nurse anesthetist.

Sec. 11. Minnesota Statutes 2012, section 148.171, subdivision 17, is amended to read:
Subd. 17. **Prescription.** "Prescription" means a written direction or an oral direction reduced to writing provided to or for an individual patient for the preparation or use of a drug or therapeutic device. In the case of a prescription for a drug, the requirements of section 151.01, subdivisions 16, 16a, and 16b, shall apply.

Sec. 12. Minnesota Statutes 2012, section 148.171, is amended by adding a subdivision to read:
Subd. 17a. **Primary care provider.** "Primary care provider" means a licensed health care provider who acts as the first point of care for comprehensive health maintenance and promotion, preventive care, and undiagnosed health concerns and who provides continuing care of varied health conditions not limited by cause, organ systems, or diagnosis.

Sec. 13. Minnesota Statutes 2012, section 148.171, subdivision 21, is amended to read:
Subd. 21. **Registered nurse anesthetist practice.** (a) "Registered nurse anesthetist practice" means the provision of anesthesia care and related services ~~within the context of collaborative management,~~ including:
(1) selecting, obtaining, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures ~~upon request, assignment, or referral by a patient's physician, dentist, or podiatrist.~~;
(2) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(3) prescribing pharmacologic and nonpharmacologic therapies; and
(4) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.
(b) A registered nurse anesthetist may perform nonsurgical therapies for acute and chronic pain symptoms upon referral and in collaboration with a physician licensed under

chapter 147. For purposes of providing nonsurgical therapies for acute and chronic pain symptoms, the registered nurse anesthetist and one or more physicians licensed under chapter 147 must have a mutually agreed upon plan that designates the scope of collaboration necessary for providing nonsurgical therapies to patients with acute and chronic pain. The registered nurse anesthetist must perform the nonsurgical therapies at the same licensed health care facility as the physician.

(c) Notwithstanding section 148.235, for purposes of providing nonsurgical pain therapies for chronic pain symptoms, the registered nurse anesthetist must have a written prescribing agreement with a physician licensed under chapter 147 that defines the delegated responsibilities related to prescribing drugs and therapeutic devices within the scope of the agreement and the practice of the registered nurse anesthetist.

Sec. 14. Minnesota Statutes 2012, section 148.171, is amended by adding a subdivision to read:

Subd. 23. **Roles of advanced practice registered nurses.** "Role" means one of four recognized advanced practice registered nurse roles: certified registered nurse anesthetist (CRNA); certified nurse-midwife (CNM); certified clinical nurse specialist (CNS); or certified nurse practitioner (CNP).

Sec. 15. Minnesota Statutes 2012, section 148.181, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The Board of Nursing consists of 16 members appointed by the governor, each of whom must be a resident of this state. Eight members must be registered nurses, each of whom must have graduated from an approved school of nursing, must be licensed and currently registered as a registered nurse in this state, and must have had at least five years experience in nursing practice, nursing administration, or nursing education immediately preceding appointment. One of the eight must have had at least two years executive or teaching experience in a baccalaureate degree nursing program approved by the board under section 148.251 during the five years immediately preceding appointment, one of the eight must have had at least two years executive or teaching experience in an associate degree nursing program approved by the board under section 148.251 during the five years immediately preceding appointment, one of the eight must be practicing professional nursing in a nursing home at the time of appointment, one of the eight must have had at least two years executive or teaching experience in a practical nursing program approved by the board under section 148.251 during the five years immediately preceding appointment, and one of the eight must be licensed and have national certification or recertification as a registered nurse anesthetist, nurse practitioner, nurse midwife, or clinical nurse specialist. Four of the eight must have had at least five years of experience in nursing practice or nursing administration immediately preceding appointment. Four members must be licensed practical nurses, each of whom must have graduated from an approved school of nursing, must be licensed and currently registered as a licensed practical nurse in this state, and must have had at least five years experience in nursing practice immediately preceding appointment. The remaining four members must be public members as defined by section 214.02.

A member may be reappointed but may not serve more than two full terms consecutively. The governor shall attempt to make appointments to the board that reflect the geography of the state. The board members who are nurses should as a whole reflect

the broad mix of practice types and sites of nurses practicing in Minnesota. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements are as provided in sections 214.07 to 214.09. Any nurse on the board who during incumbency permanently ceases to be actively engaged in the practice of nursing or otherwise becomes disqualified for board membership is automatically removed, and the governor shall fill the vacancy. The provision of staff, administrative services, and office space; the review and processing of complaints; the setting of board fees; and other provisions relating to board operations are as provided in sections 148.171 to 148.285 and chapter 214. Each member of the board shall file with the secretary of state the constitutional oath of office before beginning the term of office.

Sec. 16. Minnesota Statutes 2012, section 148.191, subdivision 2, is amended to read:
Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.285. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.285. It shall conduct or provide for surveys of such schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.285 and board rules. It shall examine, license, and renew the license of duly qualified applicants. It shall hold examinations at least once in each year at such time and place as it may determine. It shall by rule adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for registration and renewal of registration as defined in section 148.231. It shall maintain a record of all persons licensed by the board to practice advanced practice, professional, or practical nursing ~~and all registered nurses who hold Minnesota licensure and registration and are certified as advanced practice registered nurses~~. It shall cause the prosecution of all persons violating sections 148.171 to 148.285 and have power to incur such necessary expense therefor. It shall register public health nurses who meet educational and other requirements established by the board by rule, including payment of a fee. It shall have power to issue subpoenas, and to compel the attendance of witnesses and the production of all necessary documents and other evidentiary material. Any board member may administer oaths to witnesses, or take their affirmation. It shall keep a record of all its proceedings.
(b) The board shall have access to hospital, nursing home, and other medical records of a patient cared for by a nurse under review. If the board does not have a written consent from a patient permitting access to the patient's records, the nurse or facility shall delete any data in the record that identifies the patient before providing it to the board. The board shall have access to such other records as reasonably requested by the board to assist the board in its investigation. Nothing herein may be construed to allow access to any records protected by section 145.64. The board shall maintain any records obtained pursuant to this paragraph as investigative data under chapter 13.
(c) The board may accept and expend grants or gifts of money or in-kind services from a person, a public or private entity, or any other source for purposes consistent with the board's role and within the scope of its statutory authority.
(d) The board may accept registration fees for meetings and conferences conducted for the purposes of board activities that are within the scope of its authority.

Sec. 17. Minnesota Statutes 2012, section 148.211, is amended by adding a subdivision to read:

Subd. 1a. **Advanced practice registered nurse licensure.** (a) Effective January 1, 2015, no advanced practice nurse shall practice as an advanced practice registered nurse unless the advanced practice nurse is licensed by the board under this section.

(b) An applicant for a license to practice as an advanced practice registered nurse (APRN) shall apply to the board in a format prescribed by the board and pay a fee in an amount determined under section 148.243.

(c) To be eligible for licensure an applicant:

(1) must hold a current Minnesota professional nursing license or demonstrate eligibility for licensure as a registered nurse in this state;

(2) must not hold an encumbered license as a registered nurse in any state or territory;

(3) must have completed a graduate level APRN program accredited by a nursing or nursing-related accrediting body that is recognized by the United States Secretary of Education or the Council for Higher Education Accreditation as acceptable to the board. The education must be in one of the four APRN roles for at least one population focus;

(4) must be currently certified by a national certifying body recognized by the board in the APRN role and population foci appropriate to educational preparation;

(5) must report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction; and

(6) must not have committed any acts or omissions which are grounds for disciplinary action in another jurisdiction or, if these acts have been committed and would be grounds for disciplinary action as set forth in section 148.261, the board has found, after investigation, that sufficient restitution has been made.

Sec. 18. Minnesota Statutes 2012, section 148.211, is amended by adding a subdivision to read:

Subd. 1b. **Advanced practice registered nurse grandfather provision.** (a) The board shall issue a license to an applicant who does not meet the education requirements in subdivision 1a, paragraph (c), clause (3), if the applicant:

(1) is recognized by the board to practice as an advanced practice registered nurse in this state on July 1, 2014;

(2) submits an application to the board in a format prescribed by the board and the applicable fee as determined under section 148.243 by January 1, 2015; and

(3) meets the requirements under subdivision 1a, paragraph (c), clauses (1), (2), (4), (5), and (6).

(b) An advanced practice registered nurse licensed under this subdivision shall maintain all practice privileges provided to licensed advanced practice registered nurses under this chapter.

Sec. 19. Minnesota Statutes 2012, section 148.211, is amended by adding a subdivision to read:

Subd. 1c. **Postgraduate practice.** A nurse practitioner or clinical nurse specialist who qualifies for licensure as an advanced practice registered nurse must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital

or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. The nurse practitioner or clinical nurse specialist shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this subdivision, a collaborative agreement is a mutually agreed upon plan for the overall working relationship between a nurse practitioner or clinical nurse specialist, and one or more physicians licensed under chapter 147, or one or more advanced practice registered nurses licensed under this section that designates the scope of collaboration necessary to manage the care of patients. The nurse practitioner or clinical nurse specialist, and one of the collaborating physicians or advanced practice registered nurses, must have experience in providing care to patients with the same or similar medical problems.

Sec. 20. Minnesota Statutes 2012, section 148.211, subdivision 2, is amended to read:
Subd. 2. **Licensure by endorsement.** (a) The board shall issue a license to practice professional nursing or practical nursing without examination to an applicant who has been duly licensed or registered as a nurse under the laws of another state, territory, or country, if in the opinion of the board the applicant has the qualifications equivalent to the qualifications required in this state as stated in subdivision 1, all other laws not inconsistent with this section, and rules promulgated by the board.
(b) Effective January 1, 2015, an applicant for advanced practice registered nurse licensure by endorsement is eligible for licensure if the applicant meets the requirements in paragraph (a) and demonstrates:
(1) current national certification or recertification in the advanced role and population focus area; and
(2) compliance with the advanced practice nursing educational requirements that were in effect in Minnesota at the time the advanced practice registered nurse completed the advanced practice nursing education program.

Sec. 21. Minnesota Statutes 2012, section 148.231, subdivision 1, is amended to read:
Subdivision 1. **Registration.** (a) Every person licensed to practice advanced practice, professional, or practical nursing must maintain with the board a current registration for practice as ~~a~~ an advanced practice registered nurse, registered nurse, or licensed practical nurse which must be renewed at regular intervals established by the board by rule. No registration shall be issued by the board to a nurse until the nurse has submitted satisfactory evidence of compliance with the procedures and minimum requirements established by the board.
~~The fee for periodic registration for practice as a nurse shall be determined by the board by law.~~ (b) Upon receipt of the application and the required fees, as determined under section 148.243, the board shall verify the application and the evidence of completion of continuing education requirements in effect, and ~~thereupon~~ issue to the nurse registration for the next renewal period.
(c) An applicant for advanced practice registered nursing (APRN) renewal must provide evidence of current certification or recertification in the appropriate APRN role in at least one population focus by a nationally accredited certifying body recognized by the board.

Sec. 22. Minnesota Statutes 2012, section 148.231, subdivision 4, is amended to read:
Subd. 4. **Failure to register.** Any person licensed under the provisions of sections 148.171 to 148.285 who fails to register within the required period shall not be entitled to practice nursing in this state as an advanced practice registered nurse, a registered nurse, or a licensed practical nurse.

Sec. 23. Minnesota Statutes 2012, section 148.231, subdivision 5, is amended to read:
Subd. 5. **Reregistration.** A person whose registration has lapsed desiring to resume practice shall make application for reregistration, submit satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the reregistration fee for the current period to the board. A penalty fee shall be required from a person who practiced nursing without current registration. Thereupon, registration shall be issued to the person who shall immediately be placed on the practicing list as an advanced practice registered nurse, a registered nurse, or a licensed practical nurse.

Sec. 24. Minnesota Statutes 2012, section 148.233, subdivision 2, is amended to read:
Subd. 2. **Advanced practice registered nurse.** ~~An advanced practice registered nurse certified as a certified clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, or certified registered nurse anesthetist shall use the appropriate designation: RN,CNS; RN,CNM; RN,CNP; or RN,CRNA for personal identification and in documentation of services provided. Identification of educational degrees and specialty fields may be added.~~ (a) Only those persons who hold a current license to practice advanced practice registered nursing in this state may use the title advanced practice registered nurse with the role designation of certified registered nurse anesthetist, certified nurse-midwife, certified clinical nurse specialist, or certified nurse practitioner.
(b) An advanced practice registered nurse shall use the appropriate designation: APRN, CNS; APRN, CNM; APRN, CNP; or APRN, CRNA for personal identification and in documentation of services provided. Identification of educational degrees and specialty fields may be added.
(c) When providing nursing care, an advanced practice registered nurse shall provide clear identification of the appropriate advanced practice registered nurse designation.

Sec. 25. Minnesota Statutes 2012, section 148.234, is amended to read:
148.234 STATE BOUNDARIES CONSIDERATION.
A nurse may perform ~~medical~~ patient care procedures and techniques at the direction of a physician, a podiatrist, ~~or~~ a dentist, or an advanced practice registered nurse licensed in another state, United States territory, or Canadian province if the physician, podiatrist, ~~or~~ dentist, or advanced practice registered nurse gave the direction after examining the patient and issued the direction in that state, United States territory, or Canadian province. Nothing in this section allows a nurse to perform a ~~medical procedure~~ patient care procedure or technique at the direction of a physician, a podiatrist, ~~or~~ a dentist, or an advanced practice registered nurse that is illegal in this state.

Sec. 26. Minnesota Statutes 2012, section 148.235, is amended by adding a subdivision to read:
Subd. 7a. **Diagnosis, prescribing, and ordering.** Advanced practice registered

nurses are authorized to:
(1) diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;
(2) prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and
(3) plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic, and supportive services including, but not limited to, home health care, hospice, physical, and occupational therapy.

Sec. 27. Minnesota Statutes 2012, section 148.235, is amended by adding a subdivision to read:
Subd. 7b. **Drug Enforcement Administration requirements.** (a) Advanced practice registered nurses must:
(1) comply with federal Drug Enforcement Administration (DEA) requirements related to controlled substances; and
(2) file any and all of the nurse's DEA registrations and numbers with the board.
(b) The board shall maintain current records of all advanced practice registered nurses with DEA registration and numbers.

Sec. 28. Minnesota Statutes 2012, section 148.251, subdivision 1, is amended to read:
Subdivision 1. **Initial approval.** An institution desiring to conduct a nursing program shall apply to the board and submit evidence that:
(1) It is prepared to provide a program of theory and practice in advanced practice, professional, or practical nursing that meets the program approval standards adopted by the board. Instruction and required experience may be obtained in one or more institutions or agencies outside the applying institution as long as the nursing program retains accountability for all clinical and nonclinical teaching.
(2) It is prepared to meet other standards established by law and by the board.

Sec. 29. Minnesota Statutes 2012, section 148.261, subdivision 1, is amended to read:
Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license and registration of any person to practice advanced practice, professional, ~~advanced practice registered,~~ or practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee or applicant as described in section 148.262. The following are grounds for disciplinary action:
(1) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in sections 148.171 to 148.285 or rules of the board. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements.
(2) Employing fraud or deceit in procuring or attempting to procure a permit, license, or registration certificate to practice advanced practice, professional, or practical nursing or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to:
(i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or
(iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.
(3) Conviction of a felony or gross misdemeanor reasonably related to the practice of professional, advanced practice registered, or practical nursing. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered.
(4) Revocation, suspension, limitation, conditioning, or other disciplinary action against the person's professional or practical nursing license or advanced practice registered nursing credential, in another state, territory, or country; failure to report to the board that charges regarding the person's nursing license or other credential are pending in another state, territory, or country; or having been refused a license or other credential by another state, territory, or country.
(5) Failure to or inability to perform professional or practical nursing as defined in section 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a registered nurse to supervise or a licensed practical nurse to monitor adequately the performance of acts by any person working at the nurse's direction.
(6) Engaging in unprofessional conduct, including, but not limited to, a departure from or failure to conform to board rules of professional or practical nursing practice that interpret the statutory definition of professional or practical nursing as well as provide criteria for violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and prevailing professional or practical nursing practice, or any nursing practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause.
(7) Failure of an advanced practice registered nurse to practice with reasonable skill and safety or departure from or failure to conform to standards of acceptable and prevailing advanced practice registered nursing.
(8) Delegating or accepting the delegation of a nursing function or a prescribed health care function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective patient care.
(9) Actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition.
(10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or without this state.
(11) Engaging in any unethical conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause.
(12) Engaging in conduct with a patient that is sexual or may reasonably be

interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient.
(13) Obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud.
(14) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.
(15) Engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws.
(16) Improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law.
(17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of advanced practice, professional, ~~advanced practice registered,~~ or practical nursing.
(18) Violating a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of advanced practice, professional, ~~advanced practice registered,~~ or practical nursing, or a state or federal narcotics or controlled substance law.
(19) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.
(20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:
(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;
(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;
(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5 ; or
(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.
(21) Practicing outside the scope of practice authorized by section 148.171, subdivision 5 , 10, 11, 13, 14, 15, or 21.
~~(22) Practicing outside the specific field of nursing practice for which an advanced practice registered nurse is certified unless the practice is authorized under section 148.284.~~
~~(23)~~ (22) Making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148.263, or failing to cooperate with an investigation of the board as required by section 148.265.
~~(24)~~ (23) Engaging in false, fraudulent, deceptive, or misleading advertising.
~~(25)~~ (24) Failure to inform the board of the person's certification or recertification status as a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner, or certified clinical nurse specialist.
~~(26)~~ (25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse practitioner practice, or registered nurse anesthetist practice without a license and current certification or recertification by a national nurse certification organization

acceptable to the board~~, except during the period between completion of an advanced practice registered nurse course of study and certification, not to exceed six months or as authorized by the board~~.
~~(27)~~ (26) Engaging in conduct that is prohibited under section 145.412.
~~(28)~~ (27) Failing to report employment to the board as required by section 148.211, subdivision 2a , or knowingly aiding, assisting, advising, or allowing a person to fail to report as required by section 148.211, subdivision 2a.

Sec. 30. Minnesota Statutes 2012, section 148.262, subdivision 1, is amended to read:
Subdivision 1. **Forms of disciplinary action.** When the board finds that grounds for disciplinary action exist under section 148.261, subdivision 1, it may take one or more of the following actions:
(1) deny the license, registration, or registration renewal;
(2) revoke the license;
(3) suspend the license;
(4) impose limitations on the nurse's practice of advanced practice, professional, ~~advanced practice registered,~~ or practical nursing including, but not limited to, limitation of scope of practice or the requirement of practice under supervision;
(5) impose conditions on the retention of the license including, but not limited to, the imposition of retraining or rehabilitation requirements or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination, monitoring, or other review;
(6) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed as to deprive the nurse of any economic advantage gained by reason of the violation charged, to reimburse the board for the cost of counsel, investigation, and proceeding, and to discourage repeated violations;
(7) order the nurse to provide unremunerated service;
(8) censure or reprimand the nurse; or
(9) any other action justified by the facts in the case.

Sec. 31. Minnesota Statutes 2012, section 148.262, subdivision 2, is amended to read:
Subd. 2. **Automatic suspension.** Unless the board orders otherwise, a license to practice advanced practice, professional, or practical nursing is automatically suspended if:
(1) a guardian of a nurse is appointed by order of a court under sections 524.5-101 to 524.5-502;
(2) the nurse is committed by order of a court under chapter 253B; or
(3) the nurse is determined to be mentally incompetent, mentally ill, chemically dependent, or a person dangerous to the public by a court of competent jurisdiction within or without this state.
The license remains suspended until the nurse is restored to capacity by a court and, upon petition by the nurse, the suspension is terminated by the board after a hearing or upon agreement between the board and the nurse.

Sec. 32. Minnesota Statutes 2012, section 148.262, subdivision 4, is amended to read:
Subd. 4. **Reissuance.** The board may reinstate and reissue a license or registration certificate to practice advanced practice, professional, or practical nursing, but as a

condition may impose any disciplinary or corrective measure that it might originally have imposed. Any person whose license or registration has been revoked, suspended, or limited may have the license reinstated and a new registration issued when, in the discretion of the board, the action is warranted, provided that the person shall be required by the board to pay the costs of the proceedings resulting in the revocation, suspension, or limitation of the license or registration certificate and reinstatement of the license or registration certificate, and to pay the fee for the current registration period. The cost of proceedings shall include, but not be limited to, the cost paid by the board to the Office of Administrative Hearings and the Office of the Attorney General for legal and investigative services, the costs of a court reporter and witnesses, reproduction of records, board staff time, travel, and expenses, and board members' per diem reimbursements, travel costs, and expenses.

Sec. 33. Minnesota Statutes 2013 Supplement, section 148.271, is amended to read:

148.271 EXEMPTIONS.

The provisions of sections 148.171 to 148.285 shall not prohibit:

(1) The furnishing of nursing assistance in an emergency.

(2) The practice of advanced practice, professional, or practical nursing by any legally qualified advanced practice, registered, or licensed practical nurse of another state who is employed by the United States government or any bureau, division, or agency thereof while in the discharge of official duties.

(3) The practice of any profession or occupation licensed by the state, other than advanced practice, professional, or practical nursing, by any person duly licensed to practice the profession or occupation, or the performance by a person of any acts properly coming within the scope of the profession, occupation, or license.

(4) The provision of a nursing or nursing-related service by an unlicensed assistive person who has been delegated or assigned the specific function and is supervised by a registered nurse or monitored by a licensed practical nurse.

(5) The care of the sick with or without compensation when done in a nursing home covered by the provisions of section 144A.09, subdivision 1.

(6) Professional nursing practice or advanced practice registered nursing practice by a registered nurse or practical nursing practice by a licensed practical nurse licensed in another state or territory who is in Minnesota as a student enrolled in a formal, structured course of study, such as a course leading to a higher degree, certification in a nursing specialty, or to enhance skills in a clinical field, while the student is practicing in the course.

(7) Professional or practical nursing practice by a student practicing under the supervision of an instructor while the student is enrolled in a nursing program approved by the board under section 148.251.

(8) Advanced practice registered nursing as defined in section 148.171, subdivisions 5, 10, 11, 13, and 21 , by a registered nurse who is licensed and currently registered in Minnesota or another United States jurisdiction and who is enrolled as a student in a formal graduate education program leading to eligibility for certification and licensure as an advanced practice registered nurse~~; or by a registered nurse licensed and currently registered in Minnesota who has completed an advanced practice registered nurse course of study and is awaiting certification, the period not to exceed six months~~.

Sec. 34. Minnesota Statutes 2012, section 148.281, subdivision 1, is amended to read:

Subdivision 1. **Violations described.** It shall be unlawful for any person, corporation, firm, or association, to:
(1) sell or fraudulently obtain or furnish any nursing diploma, license or record, or aid or abet therein;
(2) practice advanced practice, professional, or practical nursing~~,~~ or practice as a public health nurse~~, or practice as a certified clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, or certified registered nurse anesthetist~~ under cover of any diploma, permit, license, registration certificate, advanced practice credential, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;
(3) practice advanced practice, professional, or practical nursing unless the person has been issued a temporary permit under the provisions of section 148.212 or is duly licensed and currently registered to do so under the provisions of sections 148.171 to 148.285;
(4) use the professional title nurse unless duly licensed to practice advanced practice, professional, or practical nursing under the provisions of sections 148.171 to 148.285, except as authorized by the board by rule;
(5) use any abbreviation or other designation tending to imply licensure as ~~a~~ an advanced practice registered nurse, a registered nurse, or a licensed practical nurse unless duly licensed and currently registered so to practice advanced practice, professional, or practical nursing under the provisions of sections 148.171 to 148.285 except as authorized by the board by rule;
(6) use any title, abbreviation, or other designation tending to imply certification as a certified registered nurse as defined in section 148.171, subdivision 22, unless duly certified by a national nurse certification organization;
(7) use any abbreviation or other designation tending to imply registration as a public health nurse unless duly registered by the board;
(8) practice advanced practice, professional, ~~advanced practice registered,~~ or practical nursing in a manner prohibited by the board in any limitation of a license or registration issued under the provisions of sections 148.171 to 148.285;
(9) practice advanced practice, professional, ~~advanced practice registered,~~ or practical nursing during the time a license or current registration issued under the provisions of sections 148.171 to 148.285 shall be suspended or revoked;
(10) conduct a nursing program for the education of persons to become advanced practice registered nurses, registered nurses, or licensed practical nurses unless the program has been approved by the board; and
(11) knowingly employ persons in the practice of advanced practice, professional, or practical nursing who have not been issued a current permit, license, or registration certificate to practice as a nurse in this state~~; and~~.
~~(12) knowingly employ a person in advanced practice registered nursing unless the person meets the standards and practices of sections 148.171 to 148.285.~~

Sec. 35. Minnesota Statutes 2012, section 148.281, is amended by adding a subdivision to read:
Subd. 3. **Penalty; advanced practice registered nurses.** In addition to subdivision 2, an advanced practice registered nurse who practices advanced practice registered nursing without a current license and certification or recertification shall pay a penalty fee

of $200 for the first month or part of a month and an additional $100 for each subsequent month or parts of months of practice. The amount of the penalty fee shall be calculated from the first day the advanced practice registered nurse practiced without a current advanced practice registered nurse license and certification to the last day of practice without a current license and certification, or from the first day the advanced practice registered nurse practiced without a current license and certification on file with the board until the day the current license and certification is filed with the board.

Sec. 36. Minnesota Statutes 2012, section 148.283, is amended to read:

148.283 UNAUTHORIZED PRACTICE OF PROFESSIONAL, ADVANCED PRACTICE REGISTERED, AND PRACTICAL NURSING.

The practice of advanced practice, professional, ~~advanced practice registered,~~ or practical nursing by any person who has not been licensed to practice advanced practice, professional, or practical nursing under the provisions of sections 148.171 to 148.285, or whose license has been suspended or revoked, or whose registration or national credential has expired, is hereby declared to be inimical to the public health and welfare and to constitute a public nuisance. Upon a complaint being made ~~thereof~~ by the board~~,~~ or any prosecuting officer, and upon a proper showing of the facts, the district court of the county where such practice occurred may enjoin such acts and practice. Such injunction proceeding shall be in addition to, and not in lieu of, all other penalties and remedies provided by law.

Sec. 37. **[148.2841] ADVANCED PRACTICE NURSING ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The Board of Nursing shall convene an Advanced Practice Nursing Advisory Council consisting of seven members with representation as follows:

(1) four Minnesota licensed advanced practice registered nurses, consisting of one nurse practitioner, one nurse-midwife, one clinical nurse specialist, and one nurse anesthetist;

(2) two Minnesota licensed physicians who work with advanced practice registered nurses; and

(3) one public member who is not a Minnesota licensed advanced practice registered nurse or a Minnesota licensed physician.

Subd. 2. **Terms.** Membership terms are as provided in section 15.059, subdivision 2, except that each member appointment shall be for a two-year term, with no member serving more than two consecutive terms.

Subd. 3. **Chair.** The chair shall rotate among the four advanced practice registered nurse members, with each member serving as chair for two years in the following order: nurse practitioner, nurse-midwife, clinical nurse specialist, nurse anesthetist.

Subd. 4. **Duties.** The advisory council shall:

(1) review prescribing trends of advanced practice registered nurses at an aggregate level;

(2) review emerging practices and overlap of advanced practice nursing and specialty medical practices in the six population foci and four categories of advanced practice registered nurse practice;

(3) provide recommendations to the Board of Nursing regarding advanced practice

nursing;
(4) advise the board on advanced practice registered nurse licensure and practice standards, including emerging practice trends, aggregate prescribing trends, and overlap of advanced practice registered nursing and medical practices;
(5) advise the board on distribution of information regarding advanced practice registered nurse licensure standards; and
(6) advise the board on issues related to advanced practice registered nurse practice and regulation.
Subd. 5. **Meetings.** The chair shall convene at least one meeting every six months.
Subd. 6. **Compensation.** Members shall not be compensated but shall be reimbursed for expenses under section 15.059, subdivision 3.
Subd. 7. **Removal; vacancies.** Members may be removed and vacancies shall be filled under section 15.059, subdivision 4.
Subd. 8. **Sunset.** This section sunsets February 2, 2022.

Sec. 38. Minnesota Statutes 2012, section 151.01, subdivision 23, is amended to read:
Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathy duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, ~~or~~ licensed veterinarian, or a licensed advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A~~,~~ ~~or an advanced practice nurse authorized to prescribe, dispense, and administer under section 148.235~~. For purposes of sections 151.15, subdivision 4; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.

Sec. 39. Minnesota Statutes 2012, section 152.12, is amended to read:
152.12 ~~DOCTORS~~ HEALTH CARE PROVIDERS MAY PRESCRIBE.
Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathy, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes.
Subd. 2. **Doctor of veterinary medicine.** A licensed doctor of veterinary medicine, in good faith, and in the course of professional practice only, and not for use by a human being, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, and may cause the same to be administered by an assistant under the direction and supervision of the doctor.
Subd. 3. **Research project use of controlled substances.** Any qualified person

may use controlled substances in the course of a bona fide research project but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed and administered by a person lawfully authorized to do so. Every person who engages in research involving the use of such substances shall apply annually for registration by the state Board of Pharmacy and shall pay any applicable fee specified in section 151.065, provided that such registration shall not be required if the person is covered by and has complied with federal laws covering such research projects.

Subd. 4. **Sale of controlled substances not prohibited for certain persons and entities.** Nothing in this chapter shall prohibit the sale to, or the possession of, a controlled substance in Schedule II, III, IV or V by: Registered drug wholesalers, registered manufacturers, registered pharmacies, or any licensed hospital or other licensed institutions wherein sick and injured persons are cared for or treated, or bona fide hospitals wherein animals are treated; or by licensed pharmacists, licensed doctors of medicine, doctors of osteopathy duly licensed to practice medicine, licensed doctors of dental surgery, licensed doctors of dental medicine, licensed doctors of podiatry, licensed doctors of optometry limited to Schedules IV and V, or licensed doctors of veterinary medicine when such practitioners use controlled substances within the course of their professional practice only. Nothing in this chapter shall prohibit the possession of a controlled substance in Schedule II, III, IV or V by an employee or agent of a registered drug wholesaler, registered manufacturer, or registered pharmacy, while acting in the course of employment; by a patient of a licensed doctor of medicine, a doctor of osteopathy duly licensed to practice medicine, a licensed doctor of dental surgery, a licensed doctor of dental medicine, or a licensed doctor of optometry limited to Schedules IV and V; or by the owner of an animal for which a controlled substance has been prescribed by a licensed doctor of veterinary medicine, when such controlled substances are dispensed according to law.

Subd. 5. **Analytical laboratory not prohibited from providing anonymous analysis service.** Nothing in this chapter shall prohibit an analytical laboratory from conducting an anonymous analysis service when such laboratory is registered by the Federal Drug Enforcement Administration, nor prohibit the possession of a controlled substance by an employee or agent of such analytical laboratory while acting in the course of employment.

Sec. 40. **INITIAL APPOINTMENTS AND MEETING.**

The Board of Nursing must make initial appointments to the Advanced Practice Nursing Advisory Council established under Minnesota Statutes, section 148.2841, by February 1, 2015. The president of the Board of Nursing must convene the first meeting of the advisory council by March 1, 2015.

Sec. 41. **APPROPRIATION.**

$377,000 in fiscal year 2015 is appropriated from the state government special revenue fund to the Board of Nursing to implement licensing requirements for Advanced Practice Registered Nurses. The base for this appropriation is $231,000 in fiscal years 2016 and 2017.

Sec. 42. **REPEALER.**

Minnesota Statutes 2012, sections 148.171, subdivision 6; 148.235, subdivisions 1,

2, 2a, 4, 4a, 4b, 6, and 7; 148.243, subdivision 8; and 148.284, are repealed.

Sec. 43. **EFFECTIVE DATE.**
Sections 1 to 40 are effective January 1, 2015.

ALL PAYER CLAIMS DATABASE

Section 1. Minnesota Statutes 2012, section 62U.04, subdivision 4, is amended to read:
Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:
(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;
(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and
(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.
(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out its responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.
(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.
(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.
(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 2. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision

to read:
Subd. 10. **Suspension.** Notwithstanding subdivisions 3, 3a, 3b, 3c, and 3d, the commissioner shall suspend the development and implementation of the provider peer grouping system required under this section. This suspension shall continue until the legislature authorizes the commissioner to resume this activity.

Sec. 3. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision 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.
(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.

Sec. 4. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:
Subd. 12. **All-payer claims database work group.** (a) The commissioner of health shall convene a work group to develop a framework for the expanded use of the all-payer claims database established under this section. The work group shall develop recommendations based on the following questions and other topics as identified by the work group:
(1) what should the parameters be for allowable uses of the all-payer claims data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11;
(2) what type of advisory or governing body should guide the release of data from the all-payer claims database;
(3) what type of funding or fee structure would be needed to support the expanded

use of all-payer claims data;
(4) what should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access;
(5) what are the appropriate privacy and security protections needed for the expanded use of the all-payer claims database; and
(6) what additional resources might be needed to support the expanded use of the all-payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts.
(b) The commissioner of health shall appoint the members to the work group as follows:
(1) two members recommended by the Minnesota Medical Association;
(2) two members recommended by the Minnesota Hospital Association;
(3) two members recommended by the Minnesota Council of Health Plans;
(4) one member who is a data practices expert from the Department of Administration;
(5) three members who are academic researchers with expertise in claims database analysis;
(6) two members representing two state agencies determined by the commissioner;
(7) one member representing the Minnesota Health Care Safety Net Coalition; and
(8) three members representing consumers.
(c) The commissioner of health shall submit a report on the recommendations of the work group to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services, judiciary, and civil law by February 1, 2015. In considering the recommendations provided in the report, the legislature may consider whether the currently authorized uses of the all-payer claims data under this section should continue to be authorized.
EFFECTIVE DATE. This section is effective the day following final enactment.

OMNIBUS TAX BILL #2

ARTICLE 3
SALES, USE, AND EXCISE TAXES

Sec. 30. Laws 2013, chapter 143, article 8, section 22, the effective date, is amended to read:
EFFECTIVE DATE.~~This section is effective for sales and purchases made after June 30, 2013.~~ Subdivision 7, paragraph (c), clause (2), is effective for sales and purchases made after June 30, 2013. The provisions of subdivision 7, paragraph (b), and paragraph (c), clause (8), are effective retroactively for sales and purchases made after April 1, 2009. Any vendor who paid sales or use tax on items now exempt under subdivision 7, paragraph (b), and paragraph (c), clause (8), that were sold after April 1, 2009, and before July 1, 2013, may apply for a refund of the sales or use tax paid in the manner provided

in Minnesota Statutes, section 289A.50, subdivision 1, but only if the vendor did not collect and remit sales tax on the items for which a refund is claimed. Interest on the refund shall be paid at the rate in Minnesota Statutes, section 270C.405, from 90 days after the refund claim is filed with the commissioner of revenue. The amount to make the refunds is annually appropriated to the commissioner of revenue from the general fund. Notwithstanding limitations on claims for refunds under Minnesota Statutes, section 289A.40, claims may be filed with the commissioner until June 30, 2015.

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

Sec. 31. Laws 2013, chapter 143, article 8, section 23, the effective date, is amended to read:

EFFECTIVE DATE.~~This section is effective for sales and purchases made after June 30, 2013.~~ This section is effective for sales and purchases made after June 30, 2013, except that the provision regarding accessories and supplies purchased in a transaction covered by Medicare or Medicaid that are not already exempt under Minnesota Statutes, section 297A.67, subdivision 7, and the provision defining "Medicare" and "Medicaid" are effective retroactively for sales and purchases made after April 1, 2009. Any vendor who paid sales or use tax on accessories and supplies purchased in a transaction covered by Medicare or Medicaid that are not already exempt under Minnesota Statutes, section 297A.67, subdivision 7, and that were sold after April 1, 2009, and before July 1, 2013, may apply for a refund of the sales or use tax paid in the manner provided in Minnesota Statutes, section 289A.50, subdivision 1, but only if the vendor did not collect and remit sales tax on the accessories and supplies for which a refund is claimed. Interest on the refund shall be paid at the rate in Minnesota Statutes, section 270C.405, from 90 days after the refund claim is filed with the commissioner of revenue. The amount to make the refunds is annually appropriated to the commissioner of revenue from the general fund. Notwithstanding limitations on claims for refunds under Minnesota Statutes, section 289A.40, claims may be filed with the commissioner until June 30, 2015.

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