Senators Hottinger, Dibble, Higgins, Foley and Lourey introduced--

S.F. No. 1836: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; creating a program for individuals with HIV; appropriating money; amending Minnesota Statutes 2004, section 256.9365, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [256.9370] [HIV PREVENTION AND HEALTH CARE ACCESS PROGRAM.]

Subdivision 1. [PURPOSE.] The commissioner of human services shall establish an HIV prevention and health care access program for low-income Minnesotans that:

(1) provides access to HIV treatment consistent with the guidelines of the United States Public Health Service;

(2) promotes reduction of HIV transmission through continuous and uninterrupted access to treatment consistent with the United States Public Health Service guidelines;

(3) provides uniform benefits that are comprehensive as defined by the most recent recommendations of the Institute of Medicine and medically appropriate as established by the United States Public Health Service to best meet HIV needs with a minimum of administrative cost and efforts;

(4) ensures service delivery accountability to the people it serves, including due notice; opportunities for community input; and uniform, transparent procedures communicated to current and eligible persons, their health care and social

service providers, community planning and advisory groups, and agencies established under the Ryan White Care Act;

(5) provides access to HIV treatment inclusive of treatment for substance abuse and mental health treatment as those conditions interfere with HIV treatment adherence; and

(6) provides initial and continued access to HIV treatment that is, to the maximum extent practicable, without regard to the ability of the person to pay for the services and without regard to the current or past health condition of the person with HIV.

Subd. 2. [ESTABLISHMENT.] The commissioner of human services shall establish a program to provide prescription drug coverage and basic early intervention diagnostic services and to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to secure or continue coverage under a group or individual health plan and to ensure continuous comprehensive treatment.

Subd. 3. [ELIGIBILITY REQUIREMENTS.] (a) To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must be HIV positive;

(2) the applicant must:

(i) have no health insurance coverage, or be undercovered for medications;

(ii) have no health insurance coverage because of ineligibility due to a preexisting condition;

(iii) face losing health insurance coverage due to a change in employment status; or

(iv) have limited coverage not consistent with the guidelines of the United States Public Health Service for best practice HIV treatment;

(3) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums; and

(4) the applicant must not own assets with a combined value of more than $30,000, excluding:

(i) all assets excluded under section 256B.056;

(ii) retirement accounts, Keogh plans, and pension plans; and

(iii) medical expense accounts set up through the individual's employer.

(b) To be eligible for drug reimbursement, the applicant may not be a recipient of medical assistance, medical assistance for employed persons with disabilities, or general assistance medical care.

(c) Individuals whose income and assets exceed the amounts established in paragraph (a), but who meet all the other eligibility requirements, shall be eligible for this program upon payment of a premium. The premium shall be based on the person's gross income using a sliding fee scale established by the commissioner. The premium shall not exceed ten percent of the person's annual gross income.

Subd. 4. [BENEFITS.] (a) If an individual is determined to be eligible under subdivision 3, the commissioner shall pay that portion of the group plan premium for which the individual is responsible or shall pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents. Requirements for the payment of individual plan premiums under this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance and general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

(b) If an individual is determined to be eligible under subdivision 3, the program benefits shall provide access to HIV drugs and related drug treatments included in the HIV care drug formulary established by the commissioner. The program benefits shall include those services specified in subdivision 1 and shall also provide access to early intervention treatment, including initial diagnostics, hepatitis B and C, sexually

transmitted infections, and tuberculosis screening and tests, and any treatment for HIV that is consistent with the guidelines of the United States Public Health Service for HIV best practice treatment.

(c) There shall be no co-payments or premiums or cost-shares charged to any individual determined to be eligible under subdivision 3, paragraph (a).

(d) The state may use nonfederal funds to supplement drug assistance benefits available through the Medicare Part D program.

(e) The priority use for all funds received through prescription drug rebates through HIV drug purchases must be used to purchase benefits for eligible persons.

Subd. 5. [PUBLIC ADVISORY PROCESS.] The commissioner shall establish a transparent, public advisory process for establishing and revising an HIV care drug formulary. At a minimum, the process shall include consultation with HIV health care providers, HIV social service providers, persons living with HIV, the Minnesota HIV Services Planning Council, and entities directly contracted by the federal government to administer funds from the Ryan White Care Act. Participants in this process shall be appointed in equal numbers by the commissioner and by the Minnesota HIV Services Planning Council.

Sec. 2. Minnesota Statutes 2004, section 256.9365, is amended by adding a subdivision to read:

Subd. 4. [EXPIRATION.] This section expires upon implementation of the HIV prevention and health care access program.

Sec. 3. [APPROPRIATION.]

(a) $12,400,000 is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services for the purposes of section 1.

(b) Funding sources include, but are not limited to, drug rebate funds, the Ryan White Care Act, health care access funds, and the general fund. The commissioner may use 100 percent of the funds available for the AIDS drug assistance program, but no

more than 25 percent of the funds received through the Title II formula allocation.

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective July 1, 2005.

Fiscal Note – 2005-06 Session

Bill #: S1836-0 **Complete Date:** 04/15/05

Chief Author: HOTTINGER, JOHN

Title: HIV PREV & HEALTH CARE ACCESS PRGM

Agency Name: Human Services Dept

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	6,484	8,220	10,002	12,258
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	6,484	8,220	10,002	12,258
Revenues					
General Fund	0	56	56	56	56
Net Cost <Savings>					
General Fund	0	6,428	8,164	9,946	12,202
Total Cost <Savings> to the State	0	6,428	8,164	9,946	12,202

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	2.00	2.00	2.00	2.00
Total FTE	0.00	2.00	2.00	2.00	2.00

Narrative: HF 1892/SF 1836

Bill Description

Section 1, subdivision 1 of the bill establishes a new program of HIV prevention and health care access program for low-income Minnesotans.
Section 1, subdivision 2 of the bill establishes a program to provide prescription drug coverage and basic early intervention diagnostic services.
Section 1, subdivision 3 establishes the eligibility requirements of the new program.
Section 1, subdivision 4 establishes the benefits of the new program.
Section 1, subdivision 5 establishes a public advisory process for establishing and revising an HIV care drug formulary.

Section 2 of the bill deletes existing state statute relating to HIV programs once the new program is implemented.

Section 3 appropriates 12.4 million for the SFY 2006/2007 Biennium to pay for the provisions of the bill.

Assumptions

A key assumption in this analysis is that persons with HIV will continue and seek coverage under the new state program rather than accessing the Medicare Part D drug benefit. It will be advantageous for consumers to access the state program to reduce their out-of-pocket expenses since co-pays, cost-sharing, and premium charging (for under 300% of poverty) is not allowed under the state program.

See attached sheets for more detailed assumptions.

Expenditure and/or Revenue Formula

HF 1892			**State Dollars in Thousands**			
			SFY 2006	**SFY 2007**	**SFY 2008**	**SFY 2009**
Section 1						
Subd. 3	***Establishes eligibility requirements***	Expenditures	101	154	177	203
	for new program. *Increases asset limits*	Revenues	0	0	0	0
	from 25,000-30,000. Caseload is estimated	Net State Cost	101	154	177	203
	to increase at 1.45%	FTE'S	0	0	0	0
	Allows higher income and assets	Expenditures	1,498	2,107	2,411	2,760
	if premium paid. Average monthly	Revenues	28	28	28	28
	Premiums estimated at $135.00 per month	Net State Cost	1,470	2,079	2,383	2,732
	for 25% additional recipients.	FTE'S	1.00	1.00	1.00	1.00
Subd 4	***Defines the benefits of the new program***					
	b. benefits include Hepatitis B and C	Expenditures	628	884	939	999
	at 40,000 per recipient per year.	Revenues	7	7	7	7
	The program would pay for the co-pay	Net State Cost	621	877	932	992
	for these drugs estimated at 28% of the	FTE'S	0.25	0.25	0.25	0.25
	drug cost.					
	c. No co-payments or premiums or	Expenditures	3,670	4,642	6,042	7,863
	cost shares.	Revenues	0	0	0	0
	This change reverts the programs back	Net State Cost	3,670	4,642	6,042	7,863
	to their May 2004 Forecast, before	FTE'S	0	0	0	0
	program changes occurred.					

	c. Allows supplemental funding of Medicare Part D	Expenditures	303	398	398	398
		Revenues	7	7	7	7
		Net State Cost	296	391	391	391
		FTE'S	0.25	0.25	0.25	0.25
Subd 5	***Public Advisory Process***					
	Requires new advisory process which must seek more extensive community and provider input into drug formulary. Additional administrative effort is needed.	Expenditures	35	35	35	35
		Revenues	14	14	14	14
		Net State Cost	21	21	21	21
		FTE'S	0.50	0.50	0.50	0.50
	System Costs for Bill					
	MMIS-State share	Expenditures	250	0	0	0
		Revenues	0	0	0	0
		Net State Cost	250	-	-	-
		FTE'S	0	0	0	0

HF 1892		**State Dollars in Thousands**			
All Funds		**SFY 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
	Expenditures	6,484	8,220	10,002	12,258
	Revenues	56	56	56	56
	Net State Cost	6,428	8,164	9,946	12,202
	FTE'S	2	2	2	2

Long-Term Fiscal Considerations

The provisions of this bill will cost the state an additional 22.1 million in SFY 2008/2009 Biennium.

Local Government Costs

None

References/Sources

HIV Forecast, May 2005
Continuing Care Research and Analysis

Agency Contact Name: Robert F. Meyer 582-1935
FN Coord Signature: STEVE BARTA
Date: 04/15/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/15/05 Phone: 286-5618

SF 1836 – HIV Prevention and Care Access Program
Summary of Delete-all Amendment [1]

Sec. 1, Subd. 1	**Purpose.** Defines purpose for program to include health care access for low-income individuals and HIV prevention. Updates program purpose to reflect guidelines recommended in 2004 Institute of Medicine report and impact of HIV treatments since program was initiated in early 1990s.
Sec. 1. Subd. 2	**Eligibility.** Establishes eligibility limits at 300 percent of poverty with a maximum of $25,000 in assets. Paragraphs (b), (c), and (d) establish additional eligibility limits for drug reimbursement assistance, insurance reimbursement assistance, and nutritional supplements assistance. Applies guidelines established by DHS in July 2004 for Ryan White CARE Act-funded activities to all program activities, including those funded by the State.
Sec. 1. Subd. 3	**Benefits.** Establishes guidelines for benefits available through drug reimbursement assistance, insurance reimbursement assistance and nutritional supplements assistance. Applies guidelines established by DHS in July 2004 for Ryan White CARE Act-funded activities to all program activities, including those funded by the State. – Authorizes, but does not require, commissioner to include drugs to manage HIV co-morbidity or transmission-risk factors. *[Note: Subject to future funding availability, for example federal grant program].* – Provides guidance for purchase of insurance policies that are cost-effective, but to the extent possible are consistent with treatment recommendations included in the 2004 Institute of Medicine report.
Sec. 1. Subd. 4	**Cost Sharing and Co-payments.** Applies guidelines established by DHS in July 2004 for Ryan White CARE Act-funded activities to all program activities, including those funded by the State. *[Note: Maximum limits for cost-sharing fees conform with those established by Ryan White CARE Act.]*
Sec. 1. Subd. 5	**Continuation of Care.** Authorizes commissioner to establish policies and procedures to avoid risks of interruption of care, to the maximum extent possible. Describes options for doing this as a reflection of legislative intent, but does not mandate them.
Sec. 1. Subd. 6	**Coordination with Federal Programs.** Provides for legislative oversight of proportional allocation of Ryan White CARE Act formula appropriations to ensure balanced availability of primary medical care and essential support and educational services as recommended in the 2004 Institute of Medicine report.
Sec. 1. Subd. 7	**Public Advisory Process.** Formalizes the current formulary advisory committee process. Requires coordination with other public HIV care and service planning groups in MN.

[1] Based on draft version of amendment. May vary slightly from version prepared by Senate staff for presentation to the committee.

INSURANCE PROGRAM

NEW **This program is subject to Cost Sharing (see reverse)**

The HIV/AIDS insurance program helps people with HIV get or maintain medical insurance.

Who's eligible?

In order to qualify you must be:

- Living in Minnesota
- HIV positive
- Under 300% of Federal Poverty Guidelines (see back for scale)
- 50% or less of the premium is paid by an employer
- Under $25,000 cash assets

What the program does:

The program pays medical and dental insurance premiums. This includes but is not limited to: policies carried through a COBRA extension, Medicare Supplement policies, and individually purchased policies.

DRUG REIMBURSEMENT PROGRAM

NEW **This program is subject to Cost Sharing (see reverse)**

The HIV/AIDS Drug Reimbursement Program assists with the cost of many major drugs used to treat or prevent HIV-related conditions.

Who's eligible?

In order to qualify you must be:

- Living in Minnesota
- HIV positive
- Under 300% of Federal Poverty Guidelines (see back for scale)
- Currently uninsured or insured with a drug copay
- Not enrolled in or eligible for MA, MA-EPD or GAMC or MNCare
- Under $25,000 cash assets

What the program does:

The program pays the majority of the patient's portion of the cost for all covered drugs and generic type multiple vitamins. Patients are responsible for a small co-pay ($1-$3) for each prescription up to a maximum of $20 per month. A list of currently covered drugs is available through the program office.

DENTAL PROGRAM

The HIV/AIDS Dental Program pays for routine preventative and restorative dental care.

Who's eligible?

In order to qualify you must be:

- Living in Minnesota
- HIV positive
- Under 300% of Federal Poverty Guidelines (see back for scale)
- Without dental insurance
- Under $25,000 cash assets

What the program does:

The program pays for routine diagnostic, preventive and corrective procedures furnished under the supervision of an approved dentist. Procedures covered include:

- Exams
- Prophylaxis
- X-Rays
- Amalgams
- Extractions
- Composites
- Routine Root Canal Therapy

NUTRITION PROGRAM

The HIV/AIDS Nutrition Program assists with the cost of enteral nutrition supplements.

Who's eligible?

In order to qualify you must be:

- Living in Minnesota
- HIV positive
- Under 300% of Federal Poverty Guidelines (see back for scale)
- Not eligible to receive these products through MA, MA-EPD, GAMC, or MNCare
- Under $25,000 cash assets

What the program does:

The program pays for up to $60 each month for enteral nutritional supplement products when prescribed by a physician. These products can be purchased at any pharmacy that is a Minnesota Health Care Programs provider.

HIV/AIDS Program Cost Sharing

NEW As of July 1, 2004, enrollees in the Insurance and/or Drug Reimbursement Programs will be responsible for a monthly contribution to their HIV/AIDS Program coverage. This Cost Sharing program requires enrollees with incomes between 100% and 300% of Federal Poverty to pay a fee towards their cost. The amount of the Cost Share will depend on your income. You will be informed of your Cost Share responsibility as a part of the application process.

HIV/AIDS Drug Program Co-Pays

NEW As of July 1, 2004, all enrollees in the Drug Reimbursement Program will be responsible for a minimal co-pay ($1-$3) on each prescription paid for by DHS. There is a $20 per month cap on this co-pay. Details will accompany enrollment materials.

2004 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Family Size	Poverty Guideline	300%
1	9,310	27,930
2	12,490	37,470
3	15,670	47,010
4	18,850	56,550
5	22,030	66,090
6	25,210	75,630
7	28,390	85,170
8	31,570	94,710
For each additional person, add:	3,180	9,540

Source : Federal Register: February 13, 2004 (Volume 69, Number 30)

Program Funding

These programs are paid for through State of Minnesota funds and Federal Ryan White CARE Act funds. Program availability is subject to future funding levels.

For information about other Ryan White CARE Act Programs contact:

Minnesota Department of Health
HIV Services Unit
(612) 676-5698

or Ryan White Programs,
Hennepin County Human Services Department
(612) 348-5964

To Apply

Applications are available through our office. Call or write:

HIV/AIDS Programs
Dept. of Human Services
444 Lafayette Road
St. Paul, MN 55155-3872

Metro (651) 582-1980
Statewide (800) 657-3761
Fax (651) 582-1989

For TTY/TDD Access:
Metro (651) 297-5353
Statewide (800) 627-3529

Applications are also available from our website at http://www.dhs.state.mn.us/hivaids and at many community and clinic-based sites that provide services.

Need Help Finding Help?
It is as Close as Your Telephone!

There are many HIV resources available but sometimes finding out about them is difficult. The Minnesota AIDSLINE is here to help you find them.

Here are some of the types of services the Minnesota AIDSLINE can help you find.

- financial
- housing
- supported living
- medical
- complementary health care
- legal

The Minnesota AIDSLINE can also:

- Connect you to other HIV+ individuals
- Offer emotional support
- Answer questions about HIV transmission and testing
- Refer you to case management for planning of ongoing services

Minnesota AIDSLINE hours are:
Monday - Friday 9 a.m. - 6 p.m.

Twin Cities Metro area:

(612) 373-AIDS (voice)
(612) 373-2465 (TTY/TDD)

Greater Minnesota:

(800) 248-AIDS
(888) 820-2437 (TTY/TDD)

This information is available in other forms to people with disabilities by contacting us at (651) 297-3344 (voice) or toll free at (800) 657-3761. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

DHS-4052A 4-04

Minnesota Department of Human Services

HIV/AIDS PROGRAMS

Insurance

Drug Reimbursement

Dental

Nutrition

Purpose

The purpose of the DHS HIV/AIDS programs is to help Minnesotans with HIV gain access to medical treatment.

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 1836 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [256.9370] [HIV PREVENTION AND HEALTH CARE ACCESS PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of human services shall establish a human immunodeficiency virus (HIV) prevention and health care access program for low-income Minnesotans that: (1) provides access to HIV treatment consistent with the guidelines of the United States Public Health Service; and (2) promotes reduction of HIV transmission through continuous and uninterrupted access to treatment consistent with the United States Public Health Service guidelines. The program shall provide: (1) prescription drug coverage and basic early intervention diagnostic services used to treat or prevent HIV-related conditions; (2) assistance with medical and dental insurance premiums to secure or maintain insurance coverage; (3) routine diagnostic, preventative, and restorative dental care; and (4) enteral nutritional supplement products.

Subd. 2. [ELIGIBILITY REQUIREMENTS.] (a) To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must be HIV positive;

(2) the applicant must:

(i) have no health insurance coverage, or be undercovered for medications;

(ii) have no health insurance coverage because of ineligibility due to a preexisting condition;

(iii) face losing health insurance coverage due to a change in employment status; or

(iv) have limited coverage not consistent with the guidelines of the United States Public Health Service for best practice HIV treatment;

(3) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums; and

(4) the applicant must not own assets with a combined value of more than $25,000, excluding:

(i) all assets excluded under section 256B.056;

(ii) retirement accounts, Keogh plans, and pension plans; and

(iii) medical expense accounts set up through the individual's employer; and

(5) the applicant must live in Minnesota.

(b) To be eligible for drug coverage and basic early intervention diagnostic services:

(1) the applicant may not be a recipient of medical assistance, medical assistance for employed persons with disabilities, or general assistance medical care;

(2) the applicant may be required to make a monthly cost-sharing contribution to their coverage as provided in subdivision 4; and

(3) the applicant may be required to make co-payments on each prescription as provided in subdivision 4.

(c) To be eligible for medical insurance premium assistance:

(1) the applicant must be uninsured or insured with 50 percent or less of the premium paid by an employer;

(2) the applicant may be required to make a monthly cost-sharing contribution to their coverage as provided in subdivision 4; and

(3) the applicant may be required to make co-payments on each prescription as provided in subdivision 4.

(d) To be eligible for assistance to pay for dental care or dental insurance premium, the applicant must be without dental insurance or insured with 50 percent or less of the premium paid by an employer.

(e) To be eligible for nutritional supplement assistance, the applicant must not be eligible to receive these products through medical assistance, medical assistance for employed persons with disabilities, or general assistance medical care.

Subd. 3. [BENEFITS.] (a) If an individual is determined to be eligible under subdivision 2, paragraph (b), the commissioner

shall provide access to HIV drugs or HIV-related drug treatments. The commissioner may provide access to drugs necessary to manage HIV disease comorbidity or transmission risk, which may include the treatment of hepatitis B and C, sexually transmitted infections, tuberculosis, substance abuse, or mental health. The commissioner shall determine the drug formulary in consultation with the public advisory process established in subdivision 6.

(b) If an individual is determined to be eligible under subdivision 2, paragraph (c), the commissioner shall pay that portion of the group plan premium for which the individual is responsible or shall pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents. Requirements for the payment of individual plan premiums under this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance and general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals which provides HIV treatment that is consistent with the guidelines of the United States Public Health Service, including, but not limited to, diagnostics and treatment for HIV, hepatitis B and C, sexually transmitted infections, tuberculosis, substance abuse treatment, and mental health treatment.

(c) If an individual is determined to be eligible under subdivision 2, paragraph (d), the commissioner shall provide assistance for dental care or dental insurance premium that provides access to routine diagnostic, preventative, and corrective procedures. When providing direct assistance for dental care, the commissioner may limit providers and covered procedures. When providing dental insurance premium assistance, the commissioner shall pay that portion of the group plan premium for which the individual is responsible or shall pay the individual plan premium. The commissioner shall not pay for

that portion of a premium that is attributable to other family members or dependents. Requirements for the payment of individual plan premiums under this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance and general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available that provides benefits comparable to those available through the direct dental assistance provided through this program.

(d) If an individual is determined to be eligible under subdivision 2, paragraph (e), the commissioner shall provide enteral nutritional supplement products when prescribed by a physician. The commissioner may establish a monthly financial limit for this benefit and may limit providers.

Subd. 4. [COST SHARING AND CO-PAYMENTS.] (a) The commissioner may establish cost sharing fee payments for individuals determined to be eligible under subdivision 2, paragraph (b) or (c). The cost sharing fee shall be based on an individual's gross income using a sliding scale established by the commissioner. No cost sharing fee shall be assessed for individuals whose monthly gross family income is equal to or less than 100 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums. Individuals with a monthly gross income greater than 100 percent but less than or equal to 200 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums, may be assessed cost sharing fees up to, but not exceeding, five percent of annual gross income. Individuals with a monthly gross income greater than 200 percent but less than or equal to 300 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums, may be assessed cost sharing fees up to, but not exceeding, seven percent of annual gross income.

(b) The commissioner may establish co-payments for each prescribed drug purchased under benefits defined in subdivision

2, paragraphs (b) and (c). Co-payments shall not exceed $20 per month.

(c) The commissioner may establish guidelines for individuals whose income and assets exceed the amounts established in subdivision 2, but who meet all other eligible requirements, may be eligible for this program upon payment of a cost sharing fee and co-payments. The cost sharing fee shall be based on the person's gross income using a sliding fee scale established by the commissioner. The cost sharing fee shall not exceed ten percent of the person's annual gross income.

Subd. 5. [CONTINUATION OF CARE.] The commissioner shall establish reasonable policies and procedures to ensure that initial and continued access to HIV treatment is provided, to the maximum extent practicable, without regard to the ability of the person to pay for the services and without regard to the current or past health condition of the person with HIV. This may include, but is not limited to, establishing emergency financial assistance, use of nonfederal funds to supplement drug assistance benefits available through the Medicare Part D program, or providing hardship waivers.

Subd. 6. [COORDINATION WITH FEDERAL PROGRAMS.] The commissioner shall administer the program in coordination with duties assigned in section 256.01, subdivision 20, and shall allocate these federal funds to the program:

(1) up to 25 percent of the formula appropriation;

(2) 100 percent of the AIDS drug assistance program (ADAP) appropriation; and

(3) 100 percent of the drug rebate revenue earned from purchases through this program.

Subd. 7. [PUBLIC ADVISORY PROCESS.] The commissioner shall establish a public advisory process for assessing needs and establishing policies and procedures for this program, including establishing and revising an HIV care drug formulary, in accordance with section 256.01, subdivision 20, clauses (1), (2), and (4). The process shall include consultation with HIV health care providers, HIV social service providers, persons

living with HIV, the Minnesota HIV Services Planning Council, and entities directly contracted by the federal government to administer funds from the Ryan White Care Act. A public advisory committee established for this purpose shall be appointed by the commissioner in consultation with the Minnesota HIV Services Planning Council.

Sec. 2. Minnesota Statutes 2004, section 256.9365, is amended by adding a subdivision to read:

Subd. 4. [EXPIRATION.] This section expires upon implementation of the HIV prevention and health care access program.

Sec. 3. [APPROPRIATION.]

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective July 1, 2005."

Delete the title and insert:

"A bill for an act relating to human services; creating a program for individuals with HIV; appropriating money; amending Minnesota Statutes 2004, section 256.9365, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256."

A bill for an act

relating to health; recodifying statutes and rules relating to social work; authorizing rulemaking; providing penalties; modifying provisions relating to physical therapists; providing penalties; modifying the Psychology Practice Act; phasing out licensure as a licensed psychological practitioner; modifying dental licensure provisions; establishing fees; modifying provisions for licensed professional counselors; authorizing certain rulemaking; modifying physician review; modifying information contained on prescriptions; providing recognition for the practice of respiratory therapy in emergency situations; providing that audiologists need not obtain hearing instrument dispenser certification; providing penalties; transferring oversight authority for the Office of Mental Health Practice; requiring a report; establishing penalty fees for certain credentialed health occupations; providing criminal penalties; appropriating money; amending Minnesota Statutes 2004, sections 13.383, subdivision 10; 13.411, subdivision 5; 144.335, subdivision 1; 144A.46, subdivision 2; 147.09; 147A.18, subdivisions 1, 3; 147C.05; 148.512, subdivision 6, by adding subdivisions; 148.515, by adding a subdivision; 148.5194, by adding subdivisions; 148.5195, subdivision 3; 148.6445, by adding a subdivision; 148.65, by adding subdivisions; 148.706; 148.75; 148.89, subdivision 5; 148.90, subdivision 1; 148.907, by adding a subdivision; 148.908, subdivision 2, by adding a subdivision; 148.909; 148.916, subdivision 2; 148.925, subdivision 6; 148.941, subdivision 2; 148.96, subdivision 3; 148B.53, subdivisions 1, 3; 148B.54, subdivision 2; 148B.59; 148B.60; 148B.61; 148C.03, subdivision 1; 148C.04, subdivisions 3, 4, 6; 148C.091, subdivision 1; 148C.10, subdivision 2; 148C.11, subdivisions 1, 4, 5, 6; 148C.12, subdivision 3, by adding a subdivision; 150A.01, subdivision 6a; 150A.06, subdivision 1a; 150A.10, subdivision 1a; 153A.13, subdivision 5; 153A.14, subdivisions 2i, 4, 4c; 153A.15, subdivision 1; 153A.20, subdivision 1; 214.01, subdivision 2; 214.103, subdivision 1; 245.462, subdivision 18; 245.4871, subdivision 27; 256B.0625, subdivision 38; 256J.08, subdivision 73a; 319B.02, subdivision 19; 319B.40; Laws 2003, chapter 118, section 29, as amended; proposing coding for new law in Minnesota

Statutes, chapters 148; 148B; 148C; 150A; 153A; providing coding for new law as Minnesota Statutes, chapter 148D; repealing Minnesota Statutes 2004, sections 148B.18; 148B.185; 148B.19; 148B.20; 148B.21; 148B.215; 148B.22; 148B.224; 148B.225; 148B.226; 148B.24; 148B.25; 148B.26; 148B.27; 148B.28; 148B.281; 148B.282; 148B.283; 148B.284; 148B.285; 148B.286; 148B.287; 148B.288; 148B.289; 148C.02; 148C.12, subdivision 4; 153A.14, subdivision 2a; Minnesota Rules, parts 4747.0030, subparts 11, 16; 4747.1200; 4747.1300; 5601.0100, subparts 3, 4; 8740.0100; 8740.0110; 8740.0120; 8740.0122; 8740.0130; 8740.0155; 8740.0185; 8740.0187; 8740.0200; 8740.0240; 8740.0260; 8740.0285; 8740.0300; 8740.0310; 8740.0315; 8740.0320; 8740.0325; 8740.0330; 8740.0335; 8740.0340; 8740.0345.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

BOARD OF SOCIAL WORK

Section 1. Minnesota Statutes 2004, section 13.383, subdivision 10, is amended to read:

Subd. 10. [SOCIAL WORKERS.] (a) [DISCIPLINARY DATA GENERALLY.] Data held by the Board of Social Work in connection with disciplinary matters are classified under sections ~~148B.281, subdivisions 2 and 5, and 148B.285~~ 148D.255 to 148D.270.

(b) [REPORTS OF VIOLATIONS.] Certain reports of violations submitted to the Board of Social Work are classified under ~~section 148B.284~~ sections 148D.240 to 148D.250.

(c) [CLIENT RECORDS.] Client records of a patient cared for by a social worker who is under review by the Board of Social Work are classified under ~~sections 148B.282 and 148B.286, subdivision 3~~ section 148D.230.

Sec. 2. Minnesota Statutes 2004, section 13.411, subdivision 5, is amended to read:

Subd. 5. [SOCIAL WORKERS.] Residence addresses and telephone numbers of social worker licensees are classified under ~~section 148B.285, subdivision 5~~ chapter 148D.

Sec. 3. Minnesota Statutes 2004, section 144.335, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or

examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services pursuant to sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A, 151, 153, or 153A, or Minnesota Rules, chapter 4666; (2) a home care provider licensed under section 144A.46; (3) a health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

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

Sec. 4. Minnesota Statutes 2004, section 144A.46, subdivision 2, is amended to read:

Subd. 2. [EXEMPTIONS.] The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed as a registered nurse under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

(3) a person or organization that exclusively offers, provides, or arranges for personal care assistant services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

(4) a person who is licensed under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

(5) a provider that is licensed by the commissioner of human services to provide semi-independent living services under Minnesota Rules, parts 9525.0500 to 9525.0660 when providing home care services to a person with a developmental disability;

(6) a provider that is licensed by the commissioner of human services to provide home and community-based services under Minnesota Rules, parts 9525.2000 to 9525.2140 when providing home care services to a person with a developmental disability;

(7) a person or organization that provides only home management services, if the person or organization is registered under section 144A.461; or

(8) a person who is licensed as a social worker under ~~sections 148B.18 to 148B.289~~ chapter 148D and who provides social work services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

Sec. 5. Minnesota Statutes 2004, section 147.09, is amended to read:

147.09 [EXEMPTIONS.]

Section 147.081 does not apply to, control, prevent or restrict the practice, service, or activities of:

(1) A person who is a commissioned medical officer of, a member of, or employed by, the armed forces of the United

States, the United States Public Health Service, the Veterans Administration, any federal institution or any federal agency while engaged in the performance of official duties within this state, if the person is licensed elsewhere.

(2) A licensed physician from a state or country who is in actual consultation here.

(3) A licensed or registered physician who treats the physician's home state patients or other participating patients while the physicians and those patients are participating together in outdoor recreation in this state as defined by section 86A.03, subdivision 3. A physician shall first register with the board on a form developed by the board for that purpose. The board shall not be required to promulgate the contents of that form by rule. No fee shall be charged for this registration.

(4) A student practicing under the direct supervision of a preceptor while the student is enrolled in and regularly attending a recognized medical school.

(5) A student who is in continuing training and performing the duties of an intern or resident or engaged in postgraduate work considered by the board to be the equivalent of an internship or residency in any hospital or institution approved for training by the board, provided the student has a residency permit issued by the board under section 147.0391.

(6) A person employed in a scientific, sanitary, or teaching capacity by the state university, the Department of Education, a public or private school, college, or other bona fide educational institution, a nonprofit organization, which has tax-exempt status in accordance with the Internal Revenue Code, section 501(c)(3), and is organized and operated primarily for the purpose of conducting scientific research directed towards discovering the causes of and cures for human diseases, or the state Department of Health, whose duties are entirely of a research, public health, or educational character, while engaged in such duties; provided that if the research includes the study of humans, such research shall be conducted under the

supervision of one or more physicians licensed under this chapter.

(7) Physician's assistants registered in this state.

(8) A doctor of osteopathy duly licensed by the state Board of Osteopathy under Minnesota Statutes 1961, sections 148.11 to 148.16, prior to May 1, 1963, who has not been granted a license to practice medicine in accordance with this chapter provided that the doctor confines activities within the scope of the license.

(9) Any person licensed by a health related licensing board, as defined in section 214.01, subdivision 2, or registered by the commissioner of health pursuant to section 214.13, including psychological practitioners with respect to the use of hypnosis; provided that the person confines activities within the scope of the license.

(10) A person who practices ritual circumcision pursuant to the requirements or tenets of any established religion.

(11) A Christian Scientist or other person who endeavors to prevent or cure disease or suffering exclusively by mental or spiritual means or by prayer.

(12) A physician licensed to practice medicine in another state who is in this state for the sole purpose of providing medical services at a competitive athletic event. The physician may practice medicine only on participants in the athletic event. A physician shall first register with the board on a form developed by the board for that purpose. The board shall not be required to adopt the contents of the form by rule. The physician shall provide evidence satisfactory to the board of a current unrestricted license in another state. The board shall charge a fee of $50 for the registration.

(13) A psychologist licensed under section 148.907 or a social worker licensed under ~~section 148B.21~~ chapter 148D who uses or supervises the use of a penile or vaginal plethysmograph in assessing and treating individuals suspected of engaging in aberrant sexual behavior and sex offenders.

(14) Any person issued a training course certificate or

credentialed by the Emergency Medical Services Regulatory Board established in chapter 144E, provided the person confines activities within the scope of training at the certified or credentialed level.

(15) An unlicensed complementary and alternative health care practitioner practicing according to chapter 146A.

Sec. 6. [148D.001] [CITATION.]

This chapter may be cited as the "Minnesota Board of Social Work Practice Act."

Sec. 7. [148D.010] [DEFINITIONS.]

Subdivision 1. [SCOPE.] For the purpose of this chapter, the terms in this section have the meanings given.

Subd. 2. [APPLICANT.] "Applicant" means a person who submits an application to the board for a new license, a license renewal, a change in license, an inactive license, reactivation of a license, or a voluntary termination.

Subd. 3. [APPLICATION.] "Application" means an application to the board for a new license, a license renewal, a change in license, an inactive license, reactivation of a license, or voluntary termination.

Subd. 4. [BOARD.] "Board" means the Board of Social Work created under section 148D.025.

Subd. 5. [CLIENT.] "Client" means an individual, couple, family, group, community, or organization that receives or has received social work services as described in subdivision 9.

Subd. 6. [CLINICAL PRACTICE.] "Clinical practice" means applying professional social work knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders. Treatment includes a plan based on a differential diagnosis. Treatment may include, but is not limited to, the provision of psychotherapy to individuals, couples, families, and groups. Clinical social workers may also provide the services described in subdivision 9.

Subd. 7. [INTERN.] "Intern" means a student in field placement working under the supervision or direction of a social

worker.

Subd. 8. [PERSON-IN-ENVIRONMENT PERSPECTIVE.] "Person-in-environment perspective" means viewing human behavior, development, and function in the context of one or more of the following: the environment, social functioning, mental health, and physical health.

Subd. 9. [PRACTICE OF SOCIAL WORK.] "Practice of social work" means working to maintain, restore, or improve behavioral, cognitive, emotional, mental, or social functioning of clients, in a manner that applies accepted professional social work knowledge, skills, and values, including the person-in-environment perspective, by providing in person or through telephone, video conferencing, or electronic means one or more of the social work services described in clauses (1) to (3). Social work services may address conditions that impair or limit behavioral, cognitive, emotional, mental, or social functioning. Such conditions include, but are not limited to, the following: abuse and neglect of children or vulnerable adults, addictions, developmental disorders, disabilities, discrimination, illness, injuries, poverty, and trauma. Social work services include:

(1) providing assessment and intervention through direct contact with clients, developing a plan based on information from an assessment, and providing services which include, but are not limited to, assessment, case management, client-centered advocacy, client education, consultation, counseling, crisis intervention, and referral;

(2) providing for the direct or indirect benefit of clients through administrative, educational, policy, or research services including, but not limited to:

(i) advocating for policies, programs, or services to improve the well-being of clients;

(ii) conducting research related to social work services;

(iii) developing and administering programs which provide social work services;

(iv) engaging in community organization to address social

problems through planned collective action;

(v) supervising individuals who provide social work services to clients;

(vi) supervising social workers in order to comply with the supervised practice requirements specified in sections 148D.100 to 148D.125; and

(vii) teaching professional social work knowledge, skills, and values to students; and

(3) engaging in clinical practice.

Subd. 10. [PROFESSIONAL NAME.] "Professional name" means the name a licensed social worker uses in making representations of the social worker's professional status to the public and which has been designated to the board in writing pursuant to section 148D.090.

Subd. 11. [PROFESSIONAL SOCIAL WORK KNOWLEDGE, SKILLS, AND VALUES.] "Professional social work knowledge, skills, and values" means the knowledge, skills, and values taught in programs accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board. Professional social work knowledge, skills, and values include, but are not limited to, principles of person-in-environment and the values, principles, and standards described in the Code of Ethics of the National Association of Social Workers.

Subd. 12. [SEXUAL CONDUCT.] "Sexual conduct" means any physical contact or conduct that may be reasonably interpreted as sexual, or any oral, written, electronic, or other communication that suggests engaging in physical contact or conduct that may be reasonably interpreted as sexual.

Subd. 13. [SOCIAL WORKER.] "Social worker" means an individual who:

(1) is licensed as a social worker; or

(2) has obtained a social work degree from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board and engages in the

practice of social work.

Subd. 14. [STUDENT.] "Student" means an individual who is taught professional social work knowledge, skills, and values in a program that has been accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board.

Subd. 15. [SUPERVISEE.] "Supervisee" means an individual provided evaluation and supervision or direction by a social worker.

Subd. 16. [SUPERVISION.] "Supervision" means a professional relationship between a supervisor and a social worker in which the supervisor provides evaluation and direction of the services provided by the social worker to promote competent and ethical services to clients through the continuing development of the social worker's knowledge and application of accepted professional social work knowledge, skills, and values.

Sec. 8. [148D.015] [SCOPE.]

This chapter applies to all applicants and licensees, all persons who use the title social worker, and all persons in or out of this state who provide social work services to clients who reside in this state unless there are specific applicable exemptions provided by law.

Sec. 9. [148D.020] [CHAPTER 214.]

Chapter 214 applies to the Board of Social Work unless superseded by this chapter.

Sec. 10. [148D.025] [BOARD OF SOCIAL WORK.]

Subdivision 1. [CREATION.] The Board of Social Work consists of 15 members appointed by the governor. The members are:

(1) ten social workers licensed pursuant to section 148D.055; and

(2) five public members as defined in section 214.02.

Subd. 2. [QUALIFICATIONS OF BOARD MEMBERS.] (a) All social worker members must have engaged in the practice of social work in Minnesota for at least one year during the ten years preceding their appointments.

(b) Five social worker members must be licensed social workers. The other five members must be a licensed graduate social worker, a licensed independent social worker, or a licensed independent clinical social worker.

(c) Eight social worker members must be engaged at the time of their appointment in the practice of social work in Minnesota in the following settings:

(1) one member must be engaged in the practice of social work in a county agency;

(2) one member must be engaged in the practice of social work in a state agency;

(3) one member must be engaged in the practice of social work in an elementary, middle, or secondary school;

(4) one member must be employed in a hospital or nursing home licensed under chapter 144 or 144A;

(5) two members must be engaged in the practice of social work in a private agency;

(6) one member must be engaged in the practice of social work in a clinical social work setting; and

(7) one member must be an educator engaged in regular teaching duties at a program of social work accredited by the Council on Social Work Education or a similar accreditation body designated by the board.

(d) At the time of their appointments, at least six members must reside outside of the seven-county metropolitan area.

(e) At the time of their appointments, at least five members must be persons with expertise in communities of color.

Subd. 3. [OFFICERS.] The board must annually elect from its membership a chair, vice-chair, and secretary-treasurer.

Subd. 4. [BYLAWS.] The board must adopt bylaws to govern its proceedings.

Subd. 5. [EXECUTIVE DIRECTOR.] The board must appoint and employ an executive director who is not a member of the board.

Sec. 11. [148D.030] [DUTIES OF THE BOARD.]

Subdivision 1. [DUTIES.] The board must perform the duties necessary to promote and protect the public health, safety, and

welfare through the licensure and regulation of persons who practice social work in this state. These duties include, but are not limited to:

(1) establishing the qualifications and procedures for individuals to be licensed as social workers;

(2) establishing standards of practice for social workers;

(3) holding examinations or contracting with the Association of Social Work Boards or a similar examination body designated by the board to hold examinations to assess applicants' qualifications;

(4) issuing licenses to qualified individuals pursuant to sections 148D.055 and 148D.060;

(5) taking disciplinary, adversarial, corrective, or other action pursuant to sections 148D.255 to 148D.270 when an individual violates the requirements of this chapter;

(6) assessing fees pursuant to sections 148D.175 and 148D.180; and

(7) educating social workers and the public on the requirements of the board.

Subd. 2. [RULES.] The board may adopt and enforce rules to carry out the duties specified in subdivision 1.

Sec. 12. [148D.035] [VARIANCES.]

If the effect of a requirement pursuant to this chapter is unreasonable, impossible to execute, absurd, or would impose an extreme hardship on a licensee, the board may grant a variance if the variance is consistent with promoting and protecting the public health, safety, and welfare. A variance must not be granted for core licensing standards such as substantive educational and examination requirements.

Sec. 13. [148D.040] [IMMUNITY.]

Board members, board employees, and persons engaged on behalf of the board are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the lawful execution of or relating to their duties under this chapter.

Sec. 14. [148D.045] [CONTESTED CASE HEARING.]

An applicant or a licensee who is the subject of a disciplinary or adversarial action by the board pursuant to this chapter may request a contested case hearing under sections 14.57 to 14.62. An applicant or a licensee who desires to request a contested case hearing must submit a written request to the board within 90 days after the date on which the board mailed the notification of the adverse action, except as otherwise provided in this chapter.

Sec. 15. [148D.050] [LICENSING; SCOPE OF PRACTICE.]

Subdivision 1. [REQUIREMENTS.] The practice of social work must comply with the requirements of subdivision 2, 3, 4, or 5.

Subd. 2. [LICENSED SOCIAL WORKER.] A licensed social worker may engage in social work practice except that a licensed social worker must not engage in clinical practice.

Subd. 3. [LICENSED GRADUATE SOCIAL WORKER.] A licensed graduate social worker may engage in social work practice except that a licensed graduate social worker must not engage in clinical practice except under the supervision of a licensed independent clinical social worker or an alternate supervisor pursuant to section 148D.120.

Subd. 4. [LICENSED INDEPENDENT SOCIAL WORKER.] A licensed independent social worker may engage in social work practice except that a licensed independent social worker must not engage in clinical practice except under the supervision of a licensed independent clinical social worker or an alternate supervisor pursuant to section 148D.120.

Subd. 5. [LICENSED INDEPENDENT CLINICAL SOCIAL WORKER.] A licensed independent clinical social worker may engage in social work practice, including clinical practice.

Sec. 16. [148D.055] [LICENSE REQUIREMENTS.]

Subdivision 1. [LICENSE REQUIRED.] (a) In order to practice social work, an individual must have a social work license under this section or section 148D.060, except when the individual is exempt from licensure pursuant to section 148D.065.

(b) Individuals who teach professional social work knowledge, skills, and values to students and who have a social

work degree from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board must have a social work license under this section or section 148D.060, except when the individual is exempt from licensure pursuant to section 148D.065.

Subd. 2. [QUALIFICATIONS FOR LICENSURE BY EXAMINATION AS A LICENSED SOCIAL WORKER.] (a) Except as provided in paragraph (i), to be licensed as a licensed social worker, an applicant for licensure by examination must provide evidence satisfactory to the board that the applicant:

(1) has received a baccalaureate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board;

(2) has passed the bachelors or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. Unless an applicant applies for licensure by endorsement pursuant to subdivision 7, an examination is not valid if it was taken and passed eight or more years prior to submitting a completed, signed application form provided by the board. The examination may be taken prior to completing degree requirements;

(3) has submitted a completed, signed application form provided by the board, including the applicable application fee specified in section 148D.180. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board;

(4) has submitted the criminal background check fee and a form provided by the board authorizing a criminal background check pursuant to subdivision 8;

(5) has paid the applicable license fee specified in section 148D.180; and

(6) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct

that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

(b) An application that is not completed and signed, or that is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void.

(c) A licensee granted a license by the board pursuant to paragraph (a) must meet the supervised practice requirements specified in sections 148D.100 to 148D.125. If a licensee does not meet the supervised practice requirements, the board may take action pursuant to sections 148D.255 to 148D.270.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements specified in paragraph (a) and must provide all of the information requested by the board pursuant to paragraph (d). If within one year the applicant does not meet all the requirements, or does not provide all of the information requested, the applicant is considered ineligible and the application for licensure must be closed.

(f) Except as provided in paragraph (g), an applicant may not take more than three times the bachelors or equivalent examination administered by the Association of Social Work Boards, or a similar examination body designated by the board. An applicant must receive a passing score on the bachelors or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board in no more than 18 months after the date the applicant first failed the examination.

(g) Notwithstanding paragraph (f), the board may allow an applicant to take, for a fourth or subsequent time, the bachelors or equivalent examination administered by the

Association of Social Work Boards or a similar examination body designated by the board if the applicant:

(1) meets all requirements specified in paragraphs (a) to (e) other than passing the bachelors or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board;

(2) provides to the board a description of the efforts the applicant has made to improve the applicant's score and demonstrates to the board's satisfaction that the efforts are likely to improve the score; and

(3) provides to the board letters of recommendation from two licensed social workers attesting to the applicant's ability to practice social work competently and ethically in accordance with professional social work knowledge, skills, and values.

(h) An individual must not practice social work until the individual passes the examination and receives a social work license under this section or section 148D.060. If the board has reason to believe that an applicant may be practicing social work without a license, and the applicant has failed the bachelors or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board, the board may notify the applicant's employer that the applicant is not licensed as a social worker.

(i) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (2), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a social worker if the applicant:

(1) provides evidence to the board of compliance with the requirements in paragraph (a), clauses (1) and (3) to (6), and in paragraphs (b) to (e) and (h); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2007.

Subd. 3. [QUALIFICATIONS FOR LICENSURE BY EXAMINATION AS A LICENSED GRADUATE SOCIAL WORKER.] (a) Except as provided in paragraph (i), to be licensed as a licensed graduate social worker, an applicant for licensure by examination must provide evidence satisfactory to the board that the applicant:

(1) has received a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board;

(2) has passed the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. Unless an applicant applies for licensure by endorsement pursuant to section 148D.055, subdivision 7, an examination is not valid if it was taken and passed eight or more years prior to submitting a completed, signed application form provided by the board. The examination may be taken prior to completing degree requirements;

(3) has submitted a completed, signed application form provided by the board, including the applicable application fee specified in section 148D.180. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board;

(4) has submitted the criminal background check fee and a form provided by the board authorizing a criminal background check pursuant to subdivision 8;

(5) has paid the applicable license fee specified in section 148D.180; and

(6) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

(b) An application which is not completed and signed, or which is not accompanied by the correct fee, must be returned to

the applicant, along with any fee submitted, and is void.

(c) A licensee granted a license by the board pursuant to paragraph (a) must meet the supervised practice requirements specified in sections 148D.100 to 148D.125. If a licensee does not meet the supervised practice requirements, the board may take action pursuant to sections 148D.255 to 148D.270.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements specified in paragraph (a) and must provide all of the information requested by the board pursuant to paragraph (d). If within one year the applicant does not meet all the requirements, or does not provide all of the information requested, the applicant is considered ineligible and the application for licensure must be closed.

(f) Except as provided in paragraph (g), an applicant may not take more than three times the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. An applicant must receive a passing score on the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board in no more than 18 months after the date the applicant first failed the examination.

(g) Notwithstanding paragraph (f), the board may allow an applicant to take, for a fourth or subsequent time, the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board if the applicant:

(1) meets all requirements specified in paragraphs (a) to (e) other than passing the masters or equivalent examination administered by the Association of Social Work boards or a

similar examination body designated by the board;

(2) provides to the board a description of the efforts the applicant has made to improve the applicant's score and demonstrates to the board's satisfaction that the efforts are likely to improve the score; and

(3) provides to the board letters of recommendation from two licensed social workers attesting to the applicant's ability to practice social work competently and ethically in accordance with professional social work knowledge, skills, and values.

(h) An individual must not practice social work until the individual passes the examination and receives a social work license under this section or section 148D.060. If the board has reason to believe that an applicant may be practicing social work without a license, and the applicant has failed the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board, the board may notify the applicant's employer that the applicant is not licensed as a social worker.

(i) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (2), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a social worker if the applicant:

(1) provides evidence to the board of compliance with the requirements in paragraph (a), clauses (1) and (3) to (6), and in paragraphs (b) to (e) and (h); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2007.

Subd. 4. [QUALIFICATIONS FOR LICENSURE BY EXAMINATION AS A LICENSED INDEPENDENT SOCIAL WORKER.] (a) Except as provided in paragraph (i), to be licensed as a licensed independent social worker, an applicant for licensure by examination must provide evidence satisfactory to the board that the applicant:

(1) has received a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board;

(2) has practiced social work as defined in section 148D.010, and has met the supervised practice requirements specified in sections 148D.100 to 148D.125;

(3) has passed the advanced generalist or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. Unless an applicant applies for licensure by endorsement pursuant to subdivision 7, an examination is not valid if it was taken and passed eight or more years prior to submitting a completed, signed application form provided by the board;

(4) has submitted a completed, signed application form provided by the board, including the applicable application fee specified in section 148D.180. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board;

(5) has submitted the criminal background check fee and a form provided by the board authorizing a criminal background check pursuant to subdivision 8;

(6) has paid the applicable license fee specified in section 148D.180; and

(7) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

(b) An application which is not completed and signed, or which is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void.

(c) A licensed independent social worker who practices clinical social work must meet the supervised practice requirements specified in sections 148D.100 to 148D.125. If a

licensee does not meet the supervised practice requirements, the board may take action pursuant to sections 148D.255 to 148D.270.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements specified in paragraph (a) and must provide all of the information requested by the board pursuant to paragraph (d). If within one year the applicant does not meet all the requirements, or does not provide all of the information requested, the applicant is considered ineligible and the application for licensure must be closed.

(f) Except as provided in paragraph (g), an applicant may not take more than three times the advanced generalist or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. An applicant must receive a passing score on the masters or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board in no more than 18 months after the first time the applicant failed the examination.

(g) Notwithstanding paragraph (f), the board may allow an applicant to take, for a fourth or subsequent time, the advanced generalist or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board if the applicant:

(1) meets all requirements specified in paragraphs (a) to (e) other than passing the advanced generalist or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board;

(2) provides to the board a description of the efforts the applicant has made to improve the applicant's score and demonstrates to the board's satisfaction that the efforts are

likely to improve the score; and

(3) provides to the board letters of recommendation from two licensed social workers attesting to the applicant's ability to practice social work competently and ethically in accordance with professional social work knowledge, skills, and values.

(h) An individual must not practice social work until the individual passes the examination and receives a social work license under this section or section 148D.060. If the board has reason to believe that an applicant may be practicing social work without a license, except as provided in section 148D.065, and the applicant has failed the advanced generalist or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board, the board may notify the applicant's employer that the applicant is not licensed as a social worker.

(i) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (3), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a social worker if the applicant:

(1) provides evidence to the board of compliance with the requirements in paragraph (a), clauses (1), (2), and (4) to (7), and in paragraphs (b) to (e) and (h); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2007.

Subd. 5. [QUALIFICATIONS FOR LICENSURE BY EXAMINATION AS A LICENSED INDEPENDENT CLINICAL SOCIAL WORKER.] (a) Except as provided in paragraph (h), to be licensed as a licensed independent clinical social worker, an applicant for licensure by examination must provide evidence satisfactory to the board that the applicant:

(1) has received a graduate degree in social work from a program accredited by the Council on Social Work Education, the

Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board;

(2) has practiced clinical social work as defined in section 148D.010, including both diagnosis and treatment, and has met the supervised practice requirements specified in sections 148D.100 to 148D.125;

(3) has passed the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. Unless an applicant applies for licensure by endorsement pursuant to subdivision 7, an examination is not valid if it was taken and passed eight or more years prior to submitting a completed, signed application form provided by the board;

(4) has submitted a completed, signed application form provided by the board, including the applicable application fee specified in section 148D.180. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board;

(5) has submitted the criminal background check fee and a form provided by the board authorizing a criminal background check pursuant to subdivision 8;

(6) has paid the license fee specified in section 148D.180; and

(7) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

(b) An application which is not completed and signed, or which is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void.

(c) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification,

or documentation.

(d) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements specified in paragraph (a) and must provide all of the information requested by the board pursuant to paragraph (c). If within one year the applicant does not meet all the requirements, or does not provide all of the information requested, the applicant is considered ineligible and the application for licensure must be closed.

(e) Except as provided in paragraph (f), an applicant may not take more than three times the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board. An applicant must receive a passing score on the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board no later than 18 months after the first time the applicant failed the examination.

(f) Notwithstanding paragraph (e), the board may allow an applicant to take, for a fourth or subsequent time, the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board if the applicant:

(1) meets all requirements specified in paragraphs (a) to (d) other than passing the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board;

(2) provides to the board a description of the efforts the applicant has made to improve the applicant's score and demonstrates to the board's satisfaction that the efforts are likely to improve the score; and

(3) provides to the board letters of recommendation from two licensed social workers attesting to the applicant's ability to practice social work competently and ethically in accordance with professional social work knowledge, skills, and values.

(g) An individual must not practice social work until the

individual passes the examination and receives a social work license under this section or section 148D.060. If the board has reason to believe that an applicant may be practicing social work without a license, and the applicant has failed the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body designated by the board, the board may notify the applicant's employer that the applicant is not licensed as a social worker.

(h) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (3), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a social worker if the applicant:

(1) provides evidence to the board of compliance with the requirements in paragraph (a), clauses (1), (2), and (4) to (7), and paragraphs (b) to (d) and (g); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2007.

Subd. 6. [DEGREES FROM OUTSIDE THE UNITED STATES OR CANADA.] If an applicant receives a degree from a program outside the United States or Canada that is not accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar examination body designated by the board, the degree does not fulfill the requirements specified in subdivision 2, paragraph (a), clause (1); 3, paragraph (a), clause (1); 4, paragraph (a), clause (1); or 5, paragraph (a), clause (1), unless the Council on Social Work Education or a similar accreditation body designated by the board has determined through the council's international equivalency determination service that the degree earned is equivalent to the degree required.

Subd. 7. [LICENSURE BY ENDORSEMENT.] (a) An applicant for licensure by endorsement must hold a current license or

credential to practice social work in another jurisdiction.

(b) An applicant for licensure by endorsement who meets the qualifications of paragraph (a) and who demonstrates to the satisfaction of the board that the applicant passed the examination administered by the Association of Social Work Boards or a similar examination body designated by the board for the applicable license in Minnesota is not required to retake the licensing examination.

(c) An application for licensure by endorsement must meet the applicable license requirements specified in subdivisions 1 to 6 and submit the licensure by endorsement application fee specified in section 148D.180.

Subd. 8. [CRIMINAL BACKGROUND CHECKS.] (a) Except as provided in paragraph (b), an initial license application must be accompanied by:

(1) a form provided by the board authorizing the board to complete a criminal background check; and

(2) the criminal background check fee specified by the Bureau of Criminal Apprehension.

Criminal background check fees collected by the board must be used to reimburse the Bureau of Criminal Apprehension for the criminal background checks.

(b) An applicant who has previously submitted a license application authorizing the board to complete a criminal background check is exempt from the requirement specified in paragraph (a).

(c) If a criminal background check indicates that an applicant has engaged in criminal behavior, the board may take action pursuant to sections 148D.255 to 148D.270.

Subd. 9. [EFFECTIVE DATE.] The effective date of an initial license is the day on which the board receives the applicable license fee from an applicant approved for licensure.

Subd. 10. [EXPIRATION DATE.] The expiration date of an initial license is the last day of the licensee's birth month in the second calendar year following the effective date of the initial license.

Subd. 11. [CHANGE IN LICENSE.] (a) A licensee who changes from a licensed social worker to a licensed graduate social worker, or from a licensed graduate social worker to a licensed independent social worker, or from a licensed graduate social worker or licensed independent social worker to a licensed independent clinical social worker, must pay the prorated share of the fee for the new license.

(b) The effective date of the new license is the day on which the board receives the applicable license fee from an applicant approved for the new license.

(c) The expiration date of the new license is the same date as the expiration date of the license held by the licensee prior to the change in the license.

Sec. 17. [148D.060] [TEMPORARY LICENSES.]

Subdivision 1. [STUDENTS AND OTHER PERSONS NOT CURRENTLY LICENSED IN ANOTHER JURISDICTION.] The board may issue a temporary license to practice social work to an applicant who is not licensed or credentialed to practice social work in any jurisdiction but has:

(1) applied for a license under section 148D.055;

(2) applied for a temporary license on a form provided by the board;

(3) submitted a form provided by the board authorizing the board to complete a criminal background check;

(4) passed the applicable licensure examination provided for in section 148D.055;

(5) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board; and

(6) not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice,

the board may take action pursuant to sections 148D.255 to 148D.270.

Subd. 2. [EMERGENCY SITUATIONS AND PERSONS CURRENTLY LICENSED IN ANOTHER JURISDICTION.] The board may issue a temporary license to practice social work to an applicant who is licensed or credentialed to practice social work in another jurisdiction, may or may not have applied for a license under section 148D.055, and has:

(1) applied for a temporary license on a form provided by the board;

(2) submitted a form provided by the board authorizing the board to complete a criminal background check;

(3) submitted evidence satisfactory to the board that the applicant is currently licensed or credentialed to practice social work in another jurisdiction;

(4) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board; and

(5) not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

Subd. 3. [TEACHERS.] The board may issue a temporary license to practice social work to an applicant whose permanent residence is outside the United States, who is teaching social work at an academic institution in Minnesota for a period not to exceed 12 months, who may or may not have applied for a license under section 148D.055, and who has:

(1) applied for a temporary license on a form provided by the board;

(2) submitted a form provided by the board authorizing the

board to complete a criminal background check;

(3) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or graduate degree in social work; and

(4) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148D.195 to 148D.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action pursuant to sections 148D.255 to 148D.270.

Subd. 4. [TEMPORARY LICENSE APPLICATION FEE.] An applicant for a temporary license must pay the application fee described in section 148D.180 plus the required fee for the cost of the criminal background check. Only one fee for the cost of the criminal background check must be submitted when the applicant is applying for both a temporary license and a license under section 148D.055.

Subd. 5. [TEMPORARY LICENSE TERM.] (a) A temporary license is valid until expiration, or until the board issues or denies the license pursuant to section 148D.055, or until the board revokes the temporary license, whichever comes first. A temporary license is nonrenewable.

(b) A temporary license issued pursuant to subdivision 1 or 2 expires after six months.

(c) A temporary license issued pursuant to subdivision 3 expires after 12 months.

Subd. 6. [LICENSEE WITH A TEMPORARY LICENSE WHO HAS COMPLETED REQUIREMENTS FOR A BACCALAUREATE DEGREE.] A licensee with a temporary license who has provided evidence to the board that the licensee has completed the requirements for a baccalaureate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board may temporarily engage in social work practice except that a licensee with a temporary license may not engage in clinical social work practice.

Subd. 7. [LICENSEE WITH A TEMPORARY LICENSE WHO HAS COMPLETED REQUIREMENTS FOR A GRADUATE DEGREE.] A licensee with a temporary license who has provided evidence to the board that the licensee has completed the requirements for a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body designated by the board may temporarily engage in social work practice, including clinical practice.

Subd. 8. [SUPERVISION REQUIREMENTS.] (a) Except as provided in paragraph (b), an applicant who is not currently licensed or credentialed to practice social work in another jurisdiction and who obtains a temporary license may practice social work only under the supervision of an individual licensed as a social worker who is eligible to provide supervision under sections 148D.100 to 148D.125. Before the applicant is approved for licensure, the applicant's supervisor must attest to the board's satisfaction that the applicant has practiced social work under supervision. This supervision applies toward the supervision required after licensure.

(b) If an applicant is currently licensed or credentialed to practice social work in another jurisdiction, and receives a temporary license pursuant to subdivision 3, the requirements specified in paragraph (a) do not apply. However, if an applicant with a temporary license chooses to practice social work under supervision, the supervision applies to the requirements specified in sections 148D.100 to 148D.125.

Subd. 9. [PROHIBITION ON PRACTICE.] An applicant for a temporary license must not practice social work in Minnesota, except as provided in section 148D.065, until the applicant has been granted a temporary license.

Subd. 10. [REPRESENTATION OF PROFESSIONAL STATUS.] In making representations of professional status to the public, a licensee with a temporary license must state that the licensee has a temporary license.

Subd. 11. [STANDARDS OF PRACTICE.] A licensee with a

temporary license must conduct all professional activities as a social worker in accordance with the requirements of sections 148D.195 to 148D.240.

Subd. 12. [INELIGIBILITY.] An applicant who is currently practicing social work in Minnesota in a setting that is not exempt under section 148D.065 at the time of application is ineligible for a temporary license.

Subd. 13. [REVOCATION OF TEMPORARY LICENSE.] The board may immediately revoke the temporary license of any licensee who violates any requirements of this section. The revocation must be made for cause, without notice or opportunity to be heard. A licensee whose temporary license is revoked must immediately return the temporary license to the board.

Sec. 18. [148D.065] [EXEMPTIONS.]

Subdivision 1. [OTHER PROFESSIONALS.] Nothing in this chapter may be construed to prevent members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes but is not limited to: licensed physicians, registered nurses, licensed practical nurses, licensed psychologists, psychological practitioners, probation officers, members of the clergy and Christian Science practitioners, attorneys, marriage and family therapists, alcohol and drug counselors, professional counselors, school counselors, and registered occupational therapists or certified occupational therapist assistants. These persons must not, however, hold themselves out to the public by any title or description stating or implying that they are engaged in the practice of social work, or that they are licensed to engage in the practice of social work. Persons engaged in the practice of social work are not exempt from the board's jurisdiction solely by the use of one of the titles in this subdivision.

Subd. 2. [STUDENTS.] An internship, externship, or any other social work experience that is required for the completion of an accredited program of social work does not constitute the practice of social work under this chapter.

Subd. 3. [GEOGRAPHIC WAIVER.] A geographic waiver may be granted by the board on a case-by-case basis to agencies with special regional hiring problems. The waiver is for the purpose of permitting agencies to hire individuals who do not meet the qualifications of section 148D.055 or 148D.060 to practice social work.

Subd. 4. [CITY, COUNTY, AND STATE AGENCY SOCIAL WORKERS.] The licensure of city, county, and state agency social workers is voluntary. City, county, and state agencies employing social workers are not required to employ licensed social workers.

Subd. 5. [FEDERALLY RECOGNIZED TRIBES AND PRIVATE NONPROFIT AGENCIES WITH A MINORITY FOCUS.] The licensure of social workers who are employed by federally recognized tribes, or by private nonprofit agencies whose primary service focus addresses ethnic minority populations, and who are themselves members of ethnic minority populations within those agencies, is voluntary.

Sec. 19. [148D.070] [LICENSE RENEWALS.]

Subdivision 1. [LICENSE RENEWAL TERM.] (a) If a license is renewed, the license must be renewed for a two-year renewal term. The renewal term is the period from the effective date of an initial or renewed license to the expiration date of the license.

(b) The effective date of a renewed license is the day following the expiration date of the expired license.

(c) The expiration date of a renewed license is the last day of the licensee's birth month in the second calendar year following the effective date of the renewed license.

Subd. 2. [MAILING LICENSE RENEWAL NOTICES.] The board must mail a notice for license renewal to a licensee at least 45 days before the expiration date of the license. Mailing the notice by United States mail to the licensee's last known mailing address constitutes valid mailing. Failure to receive the renewal notice does not relieve a licensee of the obligation to renew a license and to pay the renewal fee.

Subd. 3. [SUBMITTING LICENSE RENEWAL APPLICATIONS.] (a) In order to renew a license, a licensee must submit:

(1) a completed, signed application for license renewal; and

(2) the applicable renewal fee specified in section 148D.180.

The completed, signed application and renewal fee must be received by the board prior to midnight of the day of the license expiration date. For renewals submitted electronically, a "signed application" means providing an attestation as specified by the board.

(b) An application which is not completed and signed, or which is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void.

(c) The completed, signed application must include documentation that the licensee has met the continuing education requirements specified in sections 148D.130 to 148D.170 and, if applicable, the supervised practice requirements specified in sections 148D.100 to 148D.125.

(d) By submitting a renewal application, an applicant authorizes the board to:

(1) investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation;

(2) conduct an audit to determine if the applicant has met the continuing education requirements specified in sections 148D.130 to 148D.170; and

(3) if applicable, conduct an audit to determine whether the applicant has met the supervision requirements specified in sections 148D.100 to 148D.125.

(e) If a licensee's application for license renewal meets the requirements specified in paragraph (a), the licensee may continue to practice after the license expiration date until the board approves or denies the application.

Subd. 4. [RENEWAL LATE FEE.] An application that is received after the license expiration date must be accompanied

by the renewal late fee specified in section 148D.180 in addition to the applicable renewal fee. The application, renewal fee, and renewal late fee must be received by the board within 60 days of the license expiration date, or the license automatically expires.

Subd. 5. [EXPIRED LICENSE.] (a) If an application does not meet the requirements specified in subdivisions 3 and 4, the license automatically expires. A licensee whose license has expired may reactivate a license by meeting the requirements in section 148D.080 or be relicensed by meeting the requirements specified in section 148D.055.

(b) The board may take action pursuant to sections 148D.255 to 148D.270 based on a licensee's conduct before the expiration of the license.

(c) An expired license may be reactivated within one year of the expiration date specified in section 148D.080. After one year of the expiration date, an individual may apply for a new license pursuant to section 148D.055.

Sec. 20. [148D.075] [INACTIVE LICENSES.]

Subdivision 1. [INACTIVE STATUS.] (a) A licensee qualifies for inactive status under either of the circumstances described in paragraph (b) or (c).

(b) A licensee qualifies for inactive status when the licensee is granted temporary leave from active practice. A licensee qualifies for temporary leave from active practice if the licensee demonstrates to the satisfaction of the board that the licensee is not engaged in the practice of social work in any setting, including settings in which social workers are exempt from licensure pursuant to section 148D.065. A licensee who is granted temporary leave from active practice may reactivate the license pursuant to section 148D.080.

(c) A licensee qualifies for inactive status when a licensee is granted an emeritus license. A licensee qualifies for an emeritus license if the licensee demonstrates to the satisfaction of the board that:

(i) the licensee is retired from social work practice; and

(ii) the licensee is not engaged in the practice of social work in any setting, including settings in which social workers are exempt from licensure pursuant to section 148D.065.

A licensee who possesses an emeritus license may reactivate the license pursuant to section 148D.080.

Subd. 2. [APPLICATION.] A licensee may apply for inactive status:

(1) at any time by submitting an application for a temporary leave from active practice or for an emeritus license; or

(2) as an alternative to applying for the renewal of a license by so recording on the application for license renewal and submitting the completed, signed application to the board.

An application that is not completed or signed, or that is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board.

Subd. 3. [FEE.] (a) Regardless of when the application for inactive status is submitted, the temporary leave or emeritus license fee specified in section 148D.180, whichever is applicable, must accompany the application. A licensee who is approved for inactive status before the license expiration date is not entitled to receive a refund for any portion of the license or renewal fee.

(b) If an application for temporary leave is received after the license expiration date, the licensee must pay a renewal late fee as specified in section 148D.180 in addition to the temporary leave fee.

Subd. 4. [TIME LIMITS FOR TEMPORARY LEAVES.] A licensee may maintain an inactive license on temporary leave for no more than five consecutive years. If a licensee does not apply for reactivation within 60 days following the end of the consecutive five-year period, the license automatically expires.

Subd. 5. [TIME LIMITS FOR AN EMERITUS LICENSE.] A licensee with an emeritus license may not apply for reactivation pursuant

to section 148D.080 after five years following the granting of the emeritus license. However, after five years following the granting of the emeritus license, an individual may apply for new licensure pursuant to section 148D.055.

Subd. 6. [PROHIBITION ON PRACTICE.] (a) Except as provided in paragraph (b), a licensee whose license is inactive must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.

(b) The board may grant a variance to the requirements of paragraph (a) if a licensee on inactive status provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

Subd. 7. [REPRESENTATIONS OF PROFESSIONAL STATUS.] In making representations of professional status to the public, a licensee whose license is inactive must state that the license is inactive and that the licensee cannot practice social work.

Subd. 8. [DISCIPLINARY OR OTHER ACTION.] The board may resolve any pending complaints against a licensee before approving an application for inactive status. The board may take action pursuant to sections 148D.255 to 148D.270 against a licensee whose license is inactive based on conduct occurring before the license is inactive or conduct occurring while the license is inactive.

Sec. 21. [148D.080] [REACTIVATIONS.]

Subdivision 1. [MAILING NOTICES TO LICENSEES ON TEMPORARY LEAVE.] The board must mail a notice for reactivation to a licensee on temporary leave at least 45 days before the expiration date of the license pursuant to section 148D.075, subdivision 4. Mailing the notice by United States mail to the licensee's last known mailing address constitutes valid mailing. Failure to receive the reactivation notice does not relieve a licensee of the obligation to comply with the provisions of this section to reactivate a license.

Subd. 2. [REACTIVATION FROM A TEMPORARY LEAVE OR EMERITUS STATUS.] To reactivate a license from a temporary leave or

emeritus status, a licensee must do the following within the time period specified in section 148D.075, subdivisions 4 and 5:

(1) complete an application form specified by the board;

(2) document compliance with the continuing education requirements specified in subdivision 4;

(3) submit a supervision plan, if required;

(4) pay the reactivation of an inactive licensee fee specified in section 148D.180; and

(5) pay the wall certificate fee in accordance with section 148D.095, subdivision 1, paragraph (b) or (c), if the licensee needs a duplicate license.

Subd. 3. [REACTIVATION OF AN EXPIRED LICENSE.] To reactivate an expired license, a licensee must do the following within one year of the expiration date:

(1) complete an application form specified by the board;

(2) document compliance with the continuing education requirements that were in effect at the time the license expired;

(3) document compliance with the supervision requirements, if applicable, that were in effect at the time the license expired; and

(4) pay the reactivation of an expired license fee specified in section 148D.180.

Subd. 4. [CONTINUING EDUCATION REQUIREMENTS.] (a) A licensee who is on temporary leave or who has an emeritus license must obtain the continuing education hours that would be required if the license was active. At the time of reactivation, the licensee must document compliance with the continuing education requirements specified in sections 148D.130 to 148D.170.

(b) A licensee applying for reactivation pursuant to subdivision 2 or 3 may apply for a variance to the continuing education requirements pursuant to sections 148D.130 to 148D.170.

Subd. 5. [REACTIVATION OF A VOLUNTARILY TERMINATED LICENSE.] To reactivate a voluntarily terminated license, a licensee must do the following within one year of the date the

voluntary termination takes effect:

(1) complete an application form specified by the board;

(2) document compliance with the continued education requirements that were in effect at the time the license was voluntarily terminated;

(3) document compliance with the supervision requirements, if applicable, that were in effect at the time the license was voluntarily terminated; and

(4) pay the reactivation of an expired or voluntarily terminated license fee specified in section 148D.180.

Sec. 22. [148D.085] [VOLUNTARY TERMINATIONS.]

Subdivision 1. [REQUESTS FOR VOLUNTARY TERMINATION.] (a) A licensee may request voluntary termination of a license if the licensee demonstrates to the satisfaction of the board that the licensee is not engaged in the practice of social work in any setting except settings in which social workers are exempt from licensure pursuant to section 148D.065.

(b) A licensee may apply for voluntary termination:

(1) at any time by submitting an application; or

(2) as an alternative to applying for the renewal of a license by so recording on the application for license renewal and submitting the completed, signed application to the board. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board. An application that is not completed and signed must be returned to the applicant and is void.

(c) The board may resolve any pending complaints against a licensee before approving a request for voluntary termination.

Subd. 2. [APPLICATION FOR NEW LICENSURE.] A licensee who has voluntarily terminated a license may not reactivate the license after one year following the date the voluntary termination takes effect. However, a licensee who has voluntarily terminated a license may apply for a new license pursuant to section 148D.055.

Subd. 3. [PROHIBITION ON PRACTICE.] A licensee who has voluntarily terminated a license must not practice, attempt to

practice, offer to practice, or advertise or hold out as authorized to practice social work, except when the individual is exempt from licensure pursuant to section 148D.065.

Subd. 4. [DISCIPLINARY OR OTHER ACTION.] The board may take action pursuant to sections 148D.255 to 148D.270 against a licensee whose license has been terminated based on conduct occurring before the license is terminated or for practicing social work without a license.

Sec. 23. [148D.090] [NAME; CHANGE OF NAME OR ADDRESS.]

Subdivision 1. [NAME.] A licensee must use the licensee's legal name or a professional name. If the licensee uses a professional name, the licensee must inform the board in writing of both the licensee's professional name and legal name and must comply with the requirements of this section.

Subd. 2. [LEGAL NAME CHANGE.] Within 30 days after changing the licensee's legal name, a licensee must:

(1) request a new license wall certificate;

(2) provide legal verification of the name change; and

(3) pay the license wall certificate fee specified in section 148D.180.

Subd. 3. [PROFESSIONAL NAME CHANGE.] Within 30 days after changing the licensee's professional name, a licensee must:

(1) request a new license wall certificate;

(2) provide a notarized statement attesting to the name change; and

(3) pay the license wall certificate fee specified in section 148D.180.

Subd. 4. [ADDRESS OR TELEPHONE CHANGE.] When a licensee changes a mailing address, home address, work address, e-mail address, or daytime public telephone number, the licensee must notify the board of the change electronically or in writing no more than 30 days after the date of the change.

Sec. 24. [148D.095] [LICENSE CERTIFICATE OR CARD.]

Subdivision 1. [LICENSE WALL CERTIFICATE.] (a) The board must issue a new license wall certificate when the board issues a new license. No fee in addition to the applicable license fee

specified in section 148D.180 is required.

(b) The board must replace a license wall certificate when:

(1) a licensee submits an affidavit to the board that the original license wall certificate was lost, stolen, or destroyed; and

(2) the licensee submits the license wall certificate fee specified in section 148D.180.

(c) The board must issue a revised license wall certificate when:

(1) a licensee requests a revised license wall certificate pursuant to section 148D.095; and

(2) submits the license wall certificate fee specified in section 148D.180.

(d) The board must issue an additional license wall certificate when:

(1) a licensee submits a written request for a new certificate because the licensee practices in more than one location; and

(2) the licensee submits the license wall certificate fee specified in section 148D.180.

Subd. 2. [LICENSE CARD.] (a) The board must issue a new license card when the board issues a new license. No fee in addition to the applicable license fee specified in section 148D.180 is required.

(b) The board must replace a license card when a licensee submits:

(1) an affidavit to the board that the original license card was lost, stolen, or destroyed; and

(2) the license card fee specified in section 148D.180.

(c) The board must issue a revised license card when the licensee submits a written request for a new license wall certificate because of a new professional or legal name pursuant to section 148D.090, subdivision 2 or 3. No fee in addition to the one specified in subdivision 1, paragraph (b), is required.

Sec. 25. [148D.100] [LICENSED SOCIAL WORKERS; SUPERVISED PRACTICE.]

Subdivision 1. [SUPERVISION REQUIRED AFTER LICENSURE.] After receiving a license from the board as a licensed social worker, the licensed social worker must obtain at least 75 hours of supervision in accordance with the requirements of this section.

Subd. 2. [PRACTICE REQUIREMENTS.] The supervision required by subdivision 1 must be obtained during the first 4,000 hours of postbaccalaureate social work practice authorized by law. At least three hours of supervision must be obtained during every 160 hours of practice.

Subd. 3. [TYPES OF SUPERVISION.] (a) Thirty-seven and one-half hours of the supervision required by subdivision 1 must consist of one-on-one in-person supervision.

(b) Thirty-seven and one-half hours must consist of one or more of the following types of supervision, subject to the limitation in clause (3):

(1) one-on-one in-person supervision;

(2) in-person group supervision; or

(3) electronic supervision such as by telephone or video conferencing, provided that electronic supervision must not exceed 25 hours.

(c) To qualify as in-person group supervision, the group must not exceed seven members including the supervisor.

Subd. 4. [SUPERVISOR REQUIREMENTS.] The supervision required by subdivision 1 must be provided by a supervisor who:

(1) is a licensed social worker who has completed the supervised practice requirements;

(2) is a licensed graduate social worker, licensed independent social worker, or licensed independent clinical social worker; or

(3) meets the requirements specified in section 148D.120, subdivision 2.

Subd. 5. [SUPERVISEE REQUIREMENTS.] The supervisee must:

(1) to the satisfaction of the supervisor, practice competently and ethically in accordance with professional social work knowledge, skills, and values;

(2) receive supervision in the following content areas:

(i) development of professional values and responsibilities;

(ii) practice skills;

(iii) authorized scope of practice;

(iv) ensuring continuing competence; and

(v) ethical standards of practice;

(3) submit a supervision plan in accordance with section 148D.125, subdivision 1; and

(4) if the board audits the supervisee's supervised practice, submit verification of supervised practice in accordance with section 148D.125, subdivision 3.

Subd. 6. [AFTER COMPLETION OF SUPERVISION REQUIREMENTS.] A licensed social worker who fulfills the supervision requirements specified in subdivisions 1 to 5 is not required to be supervised after completion of the supervision requirements.

Subd. 7. [ATTESTATION.] The social worker and the social worker's supervisor must attest that the supervisee has met or has made progress on meeting the applicable supervision requirements in accordance with section 148D.125, subdivision 2.

Sec. 26. [148D.105] [LICENSED GRADUATE SOCIAL WORKERS; SUPERVISED PRACTICE.]

Subdivision 1. [SUPERVISION REQUIRED AFTER LICENSURE.] After receiving a license from the board as a licensed graduate social worker, a licensed graduate social worker must obtain at least 75 hours of supervision in accordance with the requirements of this section.

Subd. 2. [PRACTICE REQUIREMENTS.] The supervision required by subdivision 1 must be obtained during the first 4,000 hours of postgraduate social work practice authorized by law. At least three hours of supervision must be obtained during every 160 hours of practice.

Subd. 3. [TYPES OF SUPERVISION.] (a) Thirty-seven and one-half hours of the supervision required by subdivision 1 must consist of one-on-one in-person supervision.

(b) Thirty-seven and one-half hours must consist of one or

more of the following types of supervision, subject to the limitation in clause (3):

(1) one-on-one in-person supervision;

(2) in-person group supervision; or

(3) electronic supervision such as by telephone or video conferencing, provided that electronic supervision must not exceed 25 hours.

(c) To qualify as in-person group supervision, the group must not exceed seven members including the supervisor.

Subd. 4. [SUPERVISOR REQUIREMENTS.] The supervision required by subdivision 1 must be provided by a supervisor who meets the requirements specified in section 148D.120. The supervision must be provided:

(1) if the supervisee is not engaged in clinical practice, by a (i) licensed independent social worker, (ii) licensed graduate social worker who has completed the supervised practice requirements, or (iii) licensed independent clinical social worker;

(2) if the supervisee is engaged in clinical practice, by a licensed independent clinical social worker; or

(3) by a supervisor who meets the requirements specified in section 148D.120, subdivision 2.

Subd. 5. [SUPERVISEE REQUIREMENTS.] The supervisee must:

(1) to the satisfaction of the supervisor, practice competently and ethically in accordance with professional social work knowledge, skills, and values;

(2) receive supervision in the following content areas:

(i) development of professional values and responsibilities;

(ii) practice skills;

(iii) authorized scope of practice;

(iv) ensuring continuing competence; and

(v) ethical standards of practice;

(3) submit a supervision plan in accordance with section 148D.125, subdivision 1; and

(4) verify supervised practice in accordance with section

148D.125, subdivision 3, if:

(i) the board audits the supervisee's supervised practice; or

(ii) a licensed graduate social worker applies for a licensed independent social worker or licensed independent clinical social worker license.

Subd. 6. [LICENSED GRADUATE SOCIAL WORKERS WHO PRACTICE CLINICAL SOCIAL WORK.] (a) A licensed graduate social worker must not engage in clinical social work practice except under supervision by a licensed independent clinical social worker or an alternate supervisor designated pursuant to section 148D.120, subdivision 2.

(b) Except as provided in paragraph (c), a licensed graduate social worker must not engage in clinical social work practice under supervision for more than 8,000 hours. In order to practice clinical social work for more than 8,000 hours, a licensed graduate social worker must obtain a licensed independent clinical social worker license.

(c) Notwithstanding the requirements of paragraph (b), the board may grant a licensed graduate social worker permission to engage in clinical social work practice for more than 8,000 hours if the licensed graduate social worker petitions the board and demonstrates to the board's satisfaction that for reasons of personal hardship the licensed graduate social worker should be granted an extension to continue practicing clinical social work under supervision for up to an additional 2,000 hours.

(d) Upon completion of 4,000 hours of clinical social work practice and 75 hours of supervision in accordance with the requirements of this section, a licensed graduate social worker is eligible to apply for a licensed independent clinical social worker license pursuant to section 148D.115, subdivision 1.

Subd. 7. [LICENSED GRADUATE SOCIAL WORKERS WHO DO NOT PRACTICE CLINICAL SOCIAL WORK.] A licensed graduate social worker who fulfills the supervision requirements specified in subdivisions 1 to 5, and who does not practice clinical social work, is not required to be supervised after completion of the

supervision requirements.

Subd. 8. [ATTESTATION.] A social worker and the social worker's supervisor must attest that the supervisee has met or has made progress on meeting the applicable supervision requirements in accordance with section 148D.125, subdivision 2.

Sec. 27. [148D.110] [LICENSED INDEPENDENT SOCIAL WORKERS; SUPERVISED PRACTICE.]

Subdivision 1. [SUPERVISION REQUIRED BEFORE LICENSURE.] Before becoming licensed as a licensed independent social worker, a person must have obtained at least 75 hours of supervision during 4,000 hours of postgraduate social work practice authorized by law in accordance with the requirements of section 148D.105, subdivisions 3, 4, and 5. At least three hours of supervision must be obtained during every 160 hours of practice.

Subd. 2. [LICENSED INDEPENDENT SOCIAL WORKERS WHO PRACTICE CLINICAL SOCIAL WORK AFTER LICENSURE.] (a) After licensure, a licensed independent social worker must not engage in clinical social work practice except under supervision by a licensed independent clinical social worker or an alternate supervisor designated pursuant to section 148D.120, subdivision 2.

(b) Except as provided in paragraph (c), a licensed independent social worker must not engage in clinical social work practice under supervision for more than 8,000 hours. In order to practice clinical social work for more than 8,000 hours, a licensed independent social worker must obtain a licensed independent clinical social worker license.

(c) Notwithstanding the requirements of paragraph (b), the board may grant a licensed independent social worker permission to engage in clinical social work practice for more than 8,000 hours if the licensed independent social worker petitions the board and demonstrates to the board's satisfaction that for reasons of personal hardship the licensed independent social worker should be granted an extension to continue practicing clinical social work under supervision for up to an additional 2,000 hours.

Subd. 3. [LICENSED INDEPENDENT SOCIAL WORKERS WHO DO NOT PRACTICE CLINICAL SOCIAL WORK AFTER LICENSURE.] After licensure, a licensed independent social worker is not required to be supervised if the licensed independent social worker does not practice clinical social work.

Sec. 28. [148D.115] [LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS; SUPERVISED PRACTICE.]

Subdivision 1. [SUPERVISION REQUIRED BEFORE LICENSURE.] Before becoming licensed as a licensed independent clinical social worker, a person must have obtained at least 75 hours of supervision during 4,000 hours of postgraduate clinical practice authorized by law in accordance with the requirements of section 148D.105, subdivisions 3, 4, and 5. At least three hours of supervision must be obtained during every 160 hours of practice.

Subd. 2. [NO SUPERVISION REQUIRED AFTER LICENSURE.] After licensure, a licensed independent clinical social worker is not required to be supervised.

Sec. 29. [148D.120] [REQUIREMENTS OF SUPERVISORS.]

Subdivision 1. [SUPERVISORS LICENSED AS SOCIAL WORKERS.] (a) Except as provided in paragraph (b), to be eligible to provide supervision under this section, a social worker must attest, on a form provided by the board, that he or she has met the applicable licensure requirements specified in sections 148D.100 to 148D.115.

(b) If the board determines that supervision is not obtainable from an individual meeting the requirements specified in paragraph (a), the board may approve an alternate supervisor pursuant to subdivision 2.

Subd. 2. [ALTERNATE SUPERVISORS.] (a) The board may approve an alternate supervisor if:

(1) the board determines that supervision is not obtainable pursuant to paragraph (b);

(2) the licensee requests in the supervision plan submitted pursuant to section 148D.125, subdivision 1, that an alternate supervisor conduct the supervision;

(3) the licensee describes the proposed supervision and the name and qualifications of the proposed alternate supervisor; and

(4) the requirements of paragraph (d) are met.

(b) The board may determine that supervision is not obtainable if:

(1) the licensee provides documentation as an attachment to the supervision plan submitted pursuant to section 148D.125, subdivision 1, that the licensee has conducted a thorough search for a supervisor meeting the applicable licensure requirements specified in sections 148D.100 to 148D.115;

(2) the licensee demonstrates to the board's satisfaction that the search was unsuccessful; and

(3) the licensee describes the extent of the search and the names and locations of the persons and organizations contacted.

(c) The following are not grounds for a determination that supervision is unobtainable:

(1) obtaining a supervisor who meets the requirements of subdivision 1 would present the licensee with a financial hardship;

(2) the licensee is unable to obtain a supervisor who meets the requirements of subdivision 1 within the licensee's agency or organization and the agency or organization will not allow outside supervision; or

(3) the specialized nature of the licensee's practice requires supervision from a practitioner other than an individual licensed as a social worker.

(d) An alternate supervisor must:

(1) be an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148D.065, and who has qualifications equivalent to the applicable requirements specified in sections 148D.100 to 148D.115; or

(2) be a licensed marriage and family therapist or a mental health professional as established by section 245.462, subdivision 18, or 245.4871, subdivision 27, or an equivalent

mental health professional, as determined by the board, who is licensed or credentialed by a state, territorial, provincial, or foreign licensing agency.

In order to qualify to provide clinical supervision of a licensed graduate social worker or licensed independent social worker engaged in clinical practice, the alternate supervisor must be a mental health professional as established by section 245.462, subdivision 18, or 245.4871, subdivision 27, or an equivalent mental health professional, as determined by the board, who is licensed or credentialed by a state, territorial, provincial, or foreign licensing agency.

Sec. 30. [148D.125] [DOCUMENTATION OF SUPERVISION.]

Subdivision 1. [SUPERVISION PLAN.] (a) A social worker must submit, on a form provided by the board, a supervision plan for meeting the supervision requirements specified in sections 148D.100 to 148D.120.

(b) The supervision plan must be submitted no later than 90 days after the licensee begins a social work practice position after becoming licensed.

(c) For failure to submit the supervision plan within 90 days after beginning a social work practice position, a licensee must pay the supervision plan late fee specified in section 148D.180 when the licensee applies for license renewal.

(d) A license renewal application submitted pursuant to paragraph (a) must not be approved unless the board has received a supervision plan.

(e) The supervision plan must include the following:

(1) the name of the supervisee, the name of the agency in which the supervisee is being supervised, and the supervisee's position title;

(2) the name and qualifications of the person providing the supervision;

(3) the number of hours of one-on-one in-person supervision and the number and type of additional hours of supervision to be completed by the supervisee;

(4) the supervisee's position description;

(5) a brief description of the supervision the supervisee will receive in the following content areas:

(i) clinical practice, if applicable;

(ii) development of professional social work knowledge, skills, and values;

(iii) practice methods;

(iv) authorized scope of practice;

(v) ensuring continuing competence; and

(vi) ethical standards of practice; and

(6) if applicable, a detailed description of the supervisee's clinical social work practice, addressing:

(i) the client population, the range of presenting issues, and the diagnoses;

(ii) the clinical modalities that were utilized; and

(iii) the process utilized for determining clinical diagnoses, including the diagnostic instruments used and the role of the supervisee in the diagnostic process.

(f) The board must receive a revised supervision plan within 90 days of any of the following changes:

(1) the supervisee has a new supervisor;

(2) the supervisee begins a new social work position;

(3) the scope or content of the supervisee's social work practice changes substantially;

(4) the number of practice or supervision hours changes substantially; or

(5) the type of supervision changes as supervision is described in section 148D.100, subdivision 3, or 148D.105, subdivision 3, or as required in section 148D.115, subdivision 4.

(g) For failure to submit a revised supervised plan as required in paragraph (f), a supervisee must pay the supervision plan late fee specified in section 148D.180, when the supervisee applies for license renewal.

(h) The board must approve the supervisor and the supervision plan.

Subd. 2. [ATTESTATION.] (a) When a supervisee submits renewal application materials to the board, the supervisee and

supervisor must submit an attestation providing the following information on a form provided by the board:

(1) the name of the supervisee, the name of the agency in which the supervisee is being supervised, and the supervisee's position title;

(2) the name and qualifications of the supervisor;

(3) the number of hours and dates of each type of supervision completed;

(4) the supervisee's position description;

(5) a declaration that the supervisee has not engaged in conduct in violation of the standards of practice specified in sections 148D.195 to 148D.240;

(6) a declaration that the supervisee has practiced competently and ethically in accordance with professional social work knowledge, skills, and values; and

(7) a list of the content areas in which the supervisee has received supervision, including the following:

(i) clinical practice, if applicable;

(ii) development of professional social work knowledge, skills, and values;

(iii) practice methods;

(iv) authorized scope of practice;

(v) ensuring continuing competence; and

(vi) ethical standards of practice.

(b) The information provided on the attestation form must demonstrate to the board's satisfaction that the supervisee has met or has made progress on meeting the applicable supervised practice requirements.

Subd. 3. [VERIFICATION OF SUPERVISED PRACTICE.] (a) In addition to receiving the attestation required pursuant to subdivision 2, the board must receive verification of supervised practice if:

(1) the board audits the supervision of a supervisee pursuant to section 148D.070, subdivision 3; or

(2) an applicant applies for a license as a licensed independent social worker or as a licensed independent clinical

social worker.

(b) When verification of supervised practice is required pursuant to paragraph (a), the board must receive from the supervisor the following information on a form provided by the board:

(1) the name of the supervisee, the name of the agency in which the supervisee is being supervised, and the supervisee's position title;

(2) the name and qualifications of the supervisor;

(3) the number of hours and dates of each type of supervision completed;

(4) the supervisee's position description;

(5) a declaration that the supervisee has not engaged in conduct in violation of the standards of practice specified in sections 148D.195 to 148D.240;

(6) a declaration that the supervisee has practiced ethically and competently in accordance with professional social work knowledge, skills, and values;

(7) a list of the content areas in which the supervisee has received supervision, including the following:

(i) clinical practice, if applicable;

(ii) development of professional social work knowledge, skills, and values;

(iii) practice methods;

(iv) authorized scope of practice;

(v) ensuring continuing competence; and

(vi) ethical standards of practice; and

(8) if applicable, a detailed description of the supervisee's clinical social work practice, addressing:

(i) the client population, the range of presenting issues, and the diagnoses;

(ii) the clinical modalities that were utilized; and

(iii) the process utilized for determining clinical diagnoses, including the diagnostic instruments used and the role of the supervisee in the diagnostic process.

(c) The information provided on the verification form must

demonstrate to the board's satisfaction that the supervisee has met the applicable supervised practice requirements.

Subd. 4. [ALTERNATIVE VERIFICATION OF SUPERVISED PRACTICE.] Notwithstanding the requirements of subdivision 3, the board may accept alternative verification of supervised practice if a supervisee demonstrates to the satisfaction of the board that the supervisee is unable to locate a former supervisor to provide the required information.

Sec. 31. [148D.130] [CLOCK HOURS REQUIRED.]

Subdivision 1. [TOTAL CLOCK HOURS REQUIRED.] At the time of license renewal, a licensee must provide evidence satisfactory to the board that the licensee has, during the renewal term, completed at least 30 clock hours of continuing education.

Subd. 2. [ETHICS REQUIREMENT.] At least two of the clock hours required under subdivision 1 must be in social work ethics.

Subd. 3. [INDEPENDENT STUDY.] Independent study must not consist of more than ten clock hours of continuing education per renewal term. Independent study must be for publication, public presentation, or professional development. Independent study includes, but is not limited to, electronic study.

Subd. 4. [COURSEWORK.] One credit of coursework in a semester-based academic institution is the equivalent of 15 clock hours.

Subd. 5. [PRORATED RENEWAL TERM.] If the licensee's renewal term is prorated to be less or more than 24 months, the required number of continuing education clock hours is prorated proportionately.

Sec. 32. [148D.135] [APPROVAL OF CLOCK HOURS.]

Subdivision 1. [WAYS OF APPROVING CLOCK HOURS.] The clock hours required under section 148D.130 must be approved in one or more of the following ways:

(1) the hours must be offered by a continuing education provider approved by the board;

(2) the hours must be offered by a continuing education provider approved by the Association of Social Work Boards or a

similar examination body designated by the board;

(3) the hours must be earned through a continuing education program approved by the National Association of Social Workers; or

(4) the hours must be earned through a continuing education program approved by the board.

Subd. 2. [PREAPPROVAL NOT REQUIRED.] Providers and programs are not required to be preapproved but must meet the requirements specified in this section.

Sec. 33. [148D.140] [VARIANCES.]

The board may grant a variance to the continuing education requirements specified in section 148D.130, when a licensee demonstrates to the satisfaction of the board that the licensee is unable to complete the required number of clock hours during the renewal term. The board may allow a licensee to complete the required number of clock hours within a time frame specified by the board. The board must not allow a licensee to complete less than the required number of clock hours.

Sec. 34. [148D.145] [CONTINUING EDUCATION PROVIDERS APPROVED BY THE BOARD.]

Subdivision 1. [BOARD APPROVAL.] (a) The board must approve a continuing education provider who:

(1) submits a completed application to the board which provides the information required by subdivision 2 and which meets the criteria specified in subdivision 3; and

(2) pays the provider fee specified in section 148D.180.

(b) An approval is valid for programs offered no later than one year from the date the application is approved by the board.

Subd. 2. [INFORMATION REQUIRED.] The information that must be provided to the board includes, but is not limited to, the following:

(1) the name of the continuing education provider;

(2) the address, telephone number, and e-mail address of a contact person for the provider;

(3) a signed statement that indicates the provider understands and agrees to abide by the criteria specified in

subdivision 3; and

(4) a signed statement that indicates the provider agrees to furnish a certificate of attendance to each participant in a program offered by the provider.

Subd. 3. [CRITERIA FOR PROGRAMS OFFERED BY CONTINUING EDUCATION PROVIDERS.] (a) A continuing education provider must employ the following criteria in determining whether to offer a continuing education program:

(1) whether the material to be presented will promote the standards of practice described in sections 148D.195 to 148D.240;

(2) whether the material to be presented will contribute to the practice of social work as defined in section 148D.010;

(3) whether the material to be presented is intended for the benefit of practicing social workers; and

(4) whether the persons presenting the program are qualified in the subject matter being presented.

(b) The material presented must not be primarily procedural or primarily oriented towards business practices or self-development.

Subd. 4. [AUDITS.] (a) The board may audit programs offered by a continuing education provider approved by the board to determine compliance with the requirements of this section.

(b) A continuing education provider audited by the board must provide the documentation specified in subdivision 5.

Subd. 5. [INFORMATION REQUIRED TO BE MAINTAINED BY CONTINUING EDUCATION PROVIDERS.] For three years following the end of each program offered by a continuing education provider, the provider must maintain the following information:

(1) the title of the program;

(2) a description of the content and objectives of the program;

(3) the date of the program;

(4) the number of clock hours credited for participation in the program;

(5) the program location;

(6) the names and qualifications of the primary presenters;

(7) a description of the primary audience the program was designed for; and

(8) a list of the participants in the program.

Sec. 35. [148D.150] [CONTINUING EDUCATION PROVIDERS APPROVED BY THE ASSOCIATION OF SOCIAL WORK BOARDS.]

In order to receive credit for a program offered by a continuing education provider approved by the Association of Social Work Boards or a similar examination body designated by the board, the provider must be listed on the Association of Social Work Boards Web site as a provider currently approved by the Association of Social Work Boards or a similar examination body designated by the board.

Sec. 36. [148D.155] [CONTINUING EDUCATION PROGRAMS APPROVED BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS.]

In order to receive credit for a program approved by the National Association of Social Workers, the program must be listed on the National Association of Social Workers Web site as a program currently approved by the National Association of Social Workers.

Sec. 37. [148D.160] [CONTINUING EDUCATION PROGRAMS APPROVED BY THE BOARD.]

Subdivision 1. [REQUIRED PROGRAM CONTENT.] In order to be approved by the board, a continuing education program must:

(1) promote the standards of practice described in sections 148D.195 to 148D.240;

(2) contribute to the practice of social work as defined in section 148D.010; and

(3) not be primarily procedural or be primarily oriented towards business practices or self-development.

Subd. 2. [TYPES OF CONTINUING EDUCATION PROGRAMS.] In order to be approved by the board, a continuing education program must be one of the following: academic coursework offered by an institution of higher learning; educational workshops, seminars, or conferences offered by an organization or individual; staff training offered by a public or private

employer; or independent study.

Sec. 38. [148D.165] [CONTINUING EDUCATION REQUIREMENTS OF LICENSEES.]

Subdivision 1. [INFORMATION REQUIRED TO BE MAINTAINED BY LICENSEES.] For one year following the expiration date of a license, the licensee must maintain documentation of clock hours earned during the previous renewal term. The documentation must include the following:

(1) for educational workshops or seminars offered by an organization or at a conference, a copy of the certificate of attendance issued by the presenter or sponsor giving the following information:

(i) the name of the sponsor or presenter of the program;

(ii) the title of the workshop or seminar;

(iii) the dates the licensee participated in the program; and

(iv) the number of clock hours completed;

(2) for academic coursework offered by an institution of higher learning, a copy of a transcript giving the following information:

(i) the name of the institution offering the course;

(ii) the title of the course;

(iii) the dates the licensee participated in the course; and

(iv) the number of credits completed;

(3) for staff training offered by public or private employers, a copy of the certificate of attendance issued by the employer giving the following information:

(i) the name of the employer;

(ii) the title of the staff training;

(iii) the dates the licensee participated in the program; and

(iv) the number of clock hours completed; and

(4) for independent study, including electronic study, a written summary of the study conducted, including the following information:

(i) the topics studied;

(ii) a description of the applicability of the study to the licensee's authorized scope of practice;

(iii) the titles and authors of books and articles consulted or the name of the organization offering the study;

(iv) the dates the licensee conducted the study; and

(v) the number of clock hours the licensee conducted the study.

Subd. 2. [AUDITS.] The board may audit license renewal and reactivation applications to determine compliance with the requirements of sections 148D.130 to 148D.170. A licensee audited by the board must provide the documentation specified in subdivision 1 regardless of whether the provider or program has been approved by the board, the Association of Social Work Boards, or a similar examination body designated by the board, or the National Association of Social Workers.

Sec. 39. [148D.170] [REVOCATION OF CONTINUING EDUCATION APPROVALS.]

The board may revoke approval of a provider or of a program offered by a provider, or of an individual program approved by the board, if the board determines subsequent to the approval that the provider or program failed to meet the requirements of sections 148D.130 to 148D.170.

Sec. 40. [148D.175] [FEES.]

The fees specified in section 148D.180 are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 41. [148D.180] [FEE AMOUNTS.]

Subdivision 1. [APPLICATION FEES.] Application fees for licensure are as follows:

(1) for a licensed social worker, $45;

(2) for a licensed graduate social worker, $45;

(3) for a licensed independent social worker, $90;

(4) for a licensed independent clinical social worker, $90;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, $150.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required pursuant to section 148D.055.

Subd. 2. [LICENSE FEES.] License fees are as follows:

(1) for a licensed social worker, $115.20;

(2) for a licensed graduate social worker, $201.60;

(3) for a licensed independent social worker, $302.40;

(4) for a licensed independent clinical social worker, $331.20;

(5) for an emeritus license, $43.20; and

(6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. [RENEWAL FEES.] Renewal fees for licensure are as follows:

(1) for a licensed social worker, $115.20;

(2) for a licensed graduate social worker, $201.60;

(3) for a licensed independent social worker, $302.40; and

(4) for a licensed independent clinical social worker, $331.20.

Subd. 4. [CONTINUING EDUCATION PROVIDER FEES.] Continuing education provider fees are as follows:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period pursuant to section 148D.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period pursuant to section 148D.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period pursuant to section 148D.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period pursuant to section 148D.145,

$400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period pursuant to section 148D.145, $600.

Subd. 5. [LATE FEES.] Late fees are as follows:

(1) renewal late fee, one-half of the renewal fee specified in subdivision 3; and

(2) supervision plan late fee, $40.

Subd. 6. [LICENSE CARDS AND WALL CERTIFICATES.] (a) The fee for a license card as specified in section 148D.095 is $10.

(b) The fee for a license wall certificate as specified in section 148D.095 is $30.

Subd. 7. [REACTIVATION FEES.] Reactivation fees are as follows:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 42. [148D.185] [PURPOSE OF COMPLIANCE LAWS.]

The purpose of sections 148D.185 to 148D.290 is to protect the public by ensuring that all persons licensed as social workers meet minimum standards of practice. The board shall promptly and fairly investigate and resolve all complaints alleging violations of statutes and rules that the board is empowered to enforce and (1) take appropriate disciplinary action, adversarial action, or other action justified by the facts, or (2) enter into corrective action agreements or stipulations to cease practice, when doing so is consistent with the board's obligation to protect the public.

Sec. 43. [148D.190] [GROUNDS FOR ACTION.]

Subdivision 1. [SCOPE.] The grounds for action in subdivisions 2 to 4 and the standards of practice requirements in sections 148D.195 to 148D.240 apply to all licensees and applicants.

Subd. 2. [VIOLATIONS.] The board has grounds to take

action pursuant to sections 148D.255 to 148D.270 when a social worker violates:

(1) a statute or rule enforced by the board, including this section and sections 148D.195 to 148D.240;

(2) a federal or state law or rule related to the practice of social work; or

(3) an order, stipulation, or agreement agreed to or issued by the board.

Subd. 3. [CONDUCT BEFORE LICENSURE.] A violation of the requirements specified in this section and sections 148D.195 to 148D.240 is grounds for the board to take action under sections 148D.255 to 148D.270. The board's jurisdiction to exercise the powers provided in this section extends to an applicant or licensee's conduct that occurred before licensure if:

(1) the conduct did not meet the minimum accepted and prevailing standards of professional social work practice at the time the conduct occurred; or

(2) the conduct adversely affects the applicant or licensee's present ability to practice social work in conformity with the requirements of sections 148D.195 to 148D.240.

Subd. 4. [UNAUTHORIZED PRACTICE.] The board has grounds to take action pursuant to sections 148D.255 to 148D.270 when a social worker:

(1) practices outside the scope of practice authorized by section 148D.050;

(2) engages in the practice of social work without a social work license under section 148D.055 or 148D.060, except when the social worker is exempt from licensure pursuant to section 148D.065;

(3) provides social work services to a client who receives social work services in this state, and is not licensed pursuant to section 148D.055 or 148D.060, except when the social worker is exempt from licensure pursuant to section 148D.065.

Sec. 44. [148D.195] [REPRESENTATIONS TO CLIENTS AND PUBLIC.]

Subdivision 1. [REQUIRED DISPLAYS AND INFORMATION FOR

CLIENTS.] (a) A social worker must conspicuously display at the social worker's places of practice, or make available as a handout for all clients, information that the client has the right to the following:

(1) to be informed of the social worker's license status, education, training, and experience;

(2) to examine public data on the social worker maintained by the board;

(3) to report a complaint about the social worker's practice to the board; and

(4) to be informed of the board's mailing address, e-mail address, Web site address, and telephone number.

(b) A social worker must conspicuously display the social worker's wall certificate at the social worker's places of practice and office locations. Additional wall certificates may be requested pursuant to section 148D.095.

Subd. 2. [REPRESENTATIONS.] (a) No applicant or other individual may be represented to the public by any title incorporating the words "social work" or "social worker" unless the individual holds a license pursuant to sections 148D.055 and 148D.060 or practices in a setting exempt from licensure pursuant to section 148D.065.

(b) In all professional use of a social worker's name, the social worker must use the license designation "LSW" or "licensed social worker" for a licensed social worker, "LGSW" or "licensed graduate social worker" for a licensed graduate social worker, "LISW" or "licensed independent social worker" for a licensed independent social worker, or "LICSW" or "licensed independent clinical social worker" for a licensed independent clinical social worker.

(c) Public statements or advertisements must not be untruthful, misleading, false, fraudulent, deceptive, or potentially exploitative of clients, former clients, interns, students, supervisees, or the public.

(d) A social worker must not:

(1) use licensure status as a claim, promise, or guarantee

of successful service;

(2) obtain a license by cheating or employing fraud or deception;

(3) make false statements or misrepresentations to the board or in materials submitted to the board; or

(4) engage in conduct that has the potential to deceive or defraud a social work client, intern, student, supervisee, or the public.

Subd. 3. [INFORMATION ON CREDENTIALS.] (a) A social worker must provide accurate and factual information concerning the social worker's credentials, education, training, and experience when the information is requested by clients, potential clients, or other persons or organizations.

(b) A social worker must not misrepresent directly or by implication the social worker's license, degree, professional certifications, affiliations, or other professional qualifications in any oral or written communications to clients, potential clients, or other persons or organizations. A social worker must take reasonable steps to prevent such misrepresentations by other social workers.

(c) A social worker must not hold out as a person licensed as a social worker without having a social work license pursuant to sections 148D.055 and 148D.060.

(d) A social worker must not misrepresent directly or by implication (1) affiliations with institutions or organizations, or (2) purposes or characteristics of institutions or organizations with which the social worker is or has been affiliated.

Sec. 45. [148D.200] [COMPETENCE.]

Subdivision 1. [COMPETENCE.] (a) A social worker must provide services and hold out as competent only to the extent the social worker's education, training, license, consultation received, supervision experience, or other relevant professional experience demonstrate competence in the services provided. A social worker must make a referral to a competent professional when the services required are beyond the social worker's

competence or authorized scope of practice.

(b) When generally recognized standards do not exist with respect to an emerging area of practice, including but not limited to providing social work services through electronic means, a social worker must take the steps necessary, such as consultation or supervision, to ensure the competence of the social worker's work and to protect clients from harm.

Subd. 2. [SUPERVISION OR CONSULTATION.] Notwithstanding the completion of supervision requirements as specified in sections 148D.100 to 148D.125, a social worker must obtain supervision or engage in consultation when appropriate or necessary for competent and ethical practice.

Subd. 3. [DELEGATION OF SOCIAL WORK RESPONSIBILITIES.] (a) A social worker must not delegate a social work responsibility to another individual when the social worker knows or reasonably should know that the individual is not licensed when required to be licensed pursuant to sections 148D.055 and 148D.060.

(b) A social worker must not delegate a social work responsibility to another individual when the social worker knows or reasonably should know that the individual is not competent to assume the responsibility or perform the task.

Sec. 46. [148D.205] [IMPAIRMENT.]

Subdivision 1. [GROUNDS FOR ACTION.] The board has grounds to take action under sections 148D.255 to 148D.270 when a social worker is 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.

Subd. 2. [SELF-REPORTING.] A social worker regulated by the board who is 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, must report to the board or the health professionals services program.

Sec. 47. [148D.210] [PROFESSIONAL AND ETHICAL CONDUCT.]

The board has grounds to take action under sections

148D.255 to 148D.270 when a social worker:

(1) engages in unprofessional or unethical conduct, including any departure from or failure to conform to the minimum accepted ethical and other prevailing standards of professional social work practice, without actual injury to a social work client, intern, student, supervisee or the public needing to be established;

(2) engages in conduct that has the potential to cause harm to a client, intern, student, supervisee, or the public;

(3) demonstrates a willful or careless disregard for the health, welfare, or safety of a client, intern, student, or supervisee; or

(4) engages in acts or conduct adversely affecting the applicant or licensee's current ability or fitness to engage in social work practice, whether or not the acts or conduct occurred while engaged in the practice of social work.

Sec. 48. [148D.215] [RESPONSIBILITIES TO CLIENTS.]

Subdivision 1. [RESPONSIBILITY TO CLIENTS.] A social worker's primary professional responsibility is to the client. A social worker must respect the client's interests, including the interest in self-determination, except when required to do otherwise by law.

Subd. 2. [NONDISCRIMINATION.] A social worker must not discriminate against a client, intern, student, or supervisee or in providing services to a client, intern, or supervisee on the basis of age, gender, sexual orientation, race, color, national origin, religion, illness, disability, political affiliation, or social or economic status.

Subd. 3. [RESEARCH.] When undertaking research activities, a social worker must use accepted protocols for the protection of human subjects, including (1) establishing appropriate safeguards to protect the subject's vulnerability, and (2) obtaining the subjects' informed consent.

Sec. 49. [148D.220] [RELATIONSHIPS WITH CLIENTS, FORMER CLIENTS, AND OTHER INDIVIDUALS.]

Subdivision 1. [SOCIAL WORKER RESPONSIBILITY.] (a) A

social worker is responsible for acting professionally in relationships with clients or former clients. A client or a former client's initiation of, or attempt to engage in, or request to engage in, a personal, sexual, or business relationship is not a defense to a violation of this section.

(b) When a relationship is permitted by this section, social workers who engage in such a relationship assume the full burden of demonstrating that the relationship will not be detrimental to the client or the professional relationship.

Subd. 2. [PROFESSIONAL BOUNDARIES.] A social worker must maintain appropriate professional boundaries with a client. A social worker must not engage in practices with clients that create an unacceptable risk of client harm or of impairing a social worker's objectivity or professional judgment. A social worker must not act or fail to act in a way that, as judged by a reasonable and prudent social worker, inappropriately encourages the client to relate to the social worker outside of the boundaries of the professional relationship, or in a way that interferes with the client's ability to benefit from social work services from the social worker.

Subd. 3. [MISUSE OF PROFESSIONAL RELATIONSHIP.] A social worker must not use the professional relationship with a client, student, supervisee, or intern to further the social worker's personal, emotional, financial, sexual, religious, political, or business benefit or interests.

Subd. 4. [IMPROPER TERMINATION.] A social worker must not terminate a professional relationship for the purpose of beginning a personal, sexual, or business relationship with a client.

Subd. 5. [PERSONAL RELATIONSHIP WITH A CLIENT.] (a) Except as provided in paragraph (b), a social worker must not engage in a personal relationship with a client that creates a risk of client harm or of impairing a social worker's objectivity or professional judgment.

(b) Notwithstanding paragraph (a), if a social worker is unable to avoid a personal relationship with a client, the

social worker must take appropriate precautions, such as consultation or supervision, to address the potential for risk of client harm or of impairing a social worker's objectivity or professional judgment.

Subd. 6. [PERSONAL RELATIONSHIP WITH A FORMER CLIENT.] A social worker may engage in a personal relationship with a former client after appropriate termination of the professional relationship, except:

(1) as prohibited by subdivision 8; or

(2) if a reasonable and prudent social worker would conclude after appropriate assessment that (i) the former client is emotionally dependent on the social worker or continues to relate to the social worker as a client, or (ii) the social worker is emotionally dependent on the client or continues to relate to the former client as a social worker.

Subd. 7. [SEXUAL CONDUCT WITH A CLIENT.] A social worker must not engage in or suggest sexual conduct with a client.

Subd. 8. [SEXUAL CONDUCT WITH A FORMER CLIENT.] (a) A social worker who has engaged in diagnosing, counseling, or treating a client with mental, emotional, or behavioral disorders must not engage in or suggest sexual conduct with the former client under any circumstances unless:

(1) the social worker did not intentionally or unintentionally coerce, exploit, deceive, or manipulate the former client at any time;

(2) the social worker did not represent to the former client that sexual conduct with the social worker is consistent with or part of the client's treatment;

(3) the social worker's sexual conduct was not detrimental to the former client at any time;

(4) the former client is not emotionally dependent on the social worker and does not continue to relate to the social worker as a client; and

(5) the social worker is not emotionally dependent on the client and does not continue to relate to the former client as a social worker.

(b) If there is an alleged violation of paragraph (a), the social worker assumes the full burden of demonstrating to the board that the social worker did not intentionally or unintentionally coerce, exploit, deceive, or manipulate the client, and the social worker's sexual conduct was not detrimental to the client at any time. Upon request, a social worker must provide information to the board addressing:

(1) the amount of time that has passed since termination of services;

(2) the duration, intensity, and nature of services;

(3) the circumstances of termination of services;

(4) the former client's emotional, mental, and behavioral history;

(5) the former client's current emotional, mental, and behavioral status;

(6) the likelihood of adverse impact on the former client; and

(7) the existence of actions, conduct, or statements made by the social worker during the course of services suggesting or inviting the possibility of a sexual relationship with the client following termination of services.

(c) A social worker who has provided social work services other than those described in paragraph (a) to a client must not engage in or suggest sexual conduct with the former client if a reasonable and prudent social worker would conclude after appropriate assessment that engaging in such behavior with the former client would create an unacceptable risk of harm to the former client.

Subd. 9. [SEXUAL CONDUCT WITH A STUDENT, SUPERVISEE, OR INTERN.] (a) A social worker must not engage in or suggest sexual conduct with a student while the social worker has authority over any part of the student's academic program.

(b) A social worker supervising an intern must not engage in or suggest sexual conduct with the intern during the course of the internship.

(c) A social worker practicing social work as a supervisor

must not engage in or suggest sexual conduct with a supervisee during the period of supervision.

Subd. 10. [SEXUAL HARASSMENT.] A social worker must not engage in any physical, oral, written, or electronic behavior that a client, former client, student, supervisee, or intern may reasonably interpret as sexually harassing or sexually demeaning.

Subd. 11. [BUSINESS RELATIONSHIP WITH A CLIENT.] A social worker must not purchase goods or services from a client or otherwise engage in a business relationship with a client except when:

(1) a social worker purchases goods or services from the client and a reasonable and prudent social worker would determine that it is not practical or reasonable to obtain the goods or services from another provider; and

(2) engaging in the business relationship will not be detrimental to the client or the professional relationship.

Subd. 12. [BUSINESS RELATIONSHIP WITH A FORMER CLIENT.] A social worker may purchase goods or services from a former client or otherwise engage in a business relationship with a former client after appropriate termination of the professional relationship unless a reasonable and prudent social worker would conclude after appropriate assessment that:

(1) the former client is emotionally dependent on the social worker and purchasing goods or services from the former client or otherwise engaging in a business relationship with the former client would be detrimental to the former client; or

(2) the social worker is emotionally dependent on the former client and purchasing goods or services from the former client or otherwise engaging in a business relationship with the former client would be detrimental to the former client.

Subd. 13. [PREVIOUS SEXUAL, PERSONAL, OR BUSINESS RELATIONSHIP.] (a) A social worker must not engage in a social worker/client relationship with an individual with whom the social worker had a previous sexual relationship.

(b) A social worker must not engage in a social worker/client relationship with an individual with whom the

social worker had a previous personal or business relationship if a reasonable and prudent social worker would conclude after appropriate assessment that the social worker/client relationship would create an unacceptable risk of client harm or that the social worker's objectivity or professional judgment may be impaired.

Subd. 14. [GIVING ALCOHOL OR OTHER DRUGS TO A CLIENT.] (a) Unless authorized by law, a social worker must not offer medication or controlled substances to a client.

(b) A social worker must not accept medication or controlled substances from a client except that if authorized by law, a social worker may accept medication or controlled substances from a client for purposes of disposal or to monitor use.

(c) A social worker must not offer alcoholic beverages to a client except when such an offer is authorized or prescribed by a physician or is in accordance with a client's care plan.

(d) A social worker must not accept alcoholic beverages from a client.

Subd. 15. [RELATIONSHIP WITH A CLIENT'S FAMILY OR HOUSEHOLD MEMBER.] Subdivisions 1 to 14 apply to a social worker's relationship with a client's family or household member when a reasonable and prudent social worker would conclude after appropriate assessment that a relationship with a family or household member would create an unacceptable risk of harm to the client.

Sec. 50. [148D.225] [TREATMENT AND INTERVENTION SERVICES.]

Subdivision 1. [ASSESSMENT OR DIAGNOSIS.] A social worker must base treatment and intervention services on an assessment or diagnosis. A social worker must evaluate, on an ongoing basis, the appropriateness of the assessment or diagnosis.

Subd. 2. [ASSESSMENT OR DIAGNOSTIC INSTRUMENTS.] A social worker must not use an assessment or diagnostic instrument without adequate training. A social worker must follow standards and accepted procedures for using an assessment or diagnostic instrument. A social worker must inform a client of

the purpose before administering the instrument and must make the results available to the client.

Subd. 3. [PLAN FOR SERVICES.] A social worker must develop a plan for services that includes goals based on the assessment or diagnosis. A social worker must evaluate, on an ongoing basis, the appropriateness of the plan and the client's progress toward the goals.

Subd. 4. [RECORDS.] (a) A social worker must make and maintain current and accurate records, appropriate to the circumstances, of all services provided to a client. At a minimum, the records must contain documentation of:

(1) the assessment or diagnosis;

(2) the content of the service plan;

(3) progress with the plan and any revisions of assessment, diagnosis, or plan;

(4) any fees charged and payments made;

(5) copies of all client-written authorizations for release of information; and

(6) other information necessary to provide appropriate services.

(b) These records must be maintained by the social worker for at least seven years after the last date of service to the client. Social workers who are employed by an agency or other entity are not required to:

(1) maintain personal or separate records; or

(2) personally retain records at the conclusion of their employment.

Subd. 5. [TERMINATION OF SERVICES.] A social worker must terminate a professional relationship with a client when the social worker reasonably determines that the client is not likely to benefit from continued services or the services are no longer needed, unless the social worker is required by law to provide services. A social worker who anticipates terminating services must give reasonable notice to the client in a manner that is appropriate to the needs of the client. The social worker must provide appropriate referrals as needed or upon

request of the client.

Sec. 51. [148D.230] [CONFIDENTIALITY AND RECORDS.]

Subdivision 1. [INFORMED CONSENT.] (a) A social worker must obtain valid, informed consent, appropriate to the circumstances, before providing services to clients. When obtaining informed consent, the social worker must determine whether the client has the capacity to provide informed consent. If the client does not have the capacity to provide consent, the social worker must obtain consent for the services from the client's legal representative. The social worker must not provide services, unless authorized or required by law, if the client or the client's legal representative does not consent to the services.

(b) If a social worker determines that a client does not have the capacity to provide consent, and the client does not have a legal representative, the social worker:

(1) must, except as provided in clause (2), secure a legal representative for a client before providing services; or

(2) may, notwithstanding clause (1), provide services, except when prohibited by other applicable law, that are necessary to ensure the client's safety or to preserve the client's property or financial resources.

(c) A social worker must use clear and understandable language, including using an interpreter proficient in the client's primary language as necessary, to inform clients of the plan of services, risks related to the plan, limits to services, relevant costs, terms of payment, reasonable alternatives, the client's right to refuse or withdraw consent, and the time frame covered by the consent.

Subd. 2. [MANDATORY REPORTING AND DISCLOSURE OF CLIENT INFORMATION.] At the beginning of a professional relationship and during the professional relationship as necessary and appropriate, a social worker must inform the client of those circumstances under which the social worker may be required to disclose client information specified in subdivision 3, paragraph (a), without the client's consent.

Subd. 3. [CONFIDENTIALITY OF CLIENT INFORMATION.] (a) A social worker must ensure the confidentiality of all client information obtained in the course of the social worker/client relationship and all client information otherwise obtained by the social worker that is relevant to the social worker/client relationship. Except as provided in this section, client information may be disclosed or released only with the client's or the client's legal representative's valid informed consent, appropriate to the circumstances, except when otherwise required by law. A social worker must seek consent to disclose or release client information only when such disclosure or release is necessary to provide social work services.

(b) A social worker must continue to maintain confidentiality of the client information specified in paragraph (a) upon termination of the professional relationship including upon the death of the client, except as provided under this section or other applicable law.

(c) A social worker must limit access to the client information specified in paragraph (a) in a social worker's agency to appropriate agency staff whose duties require access.

Subd. 4. [RELEASE OF CLIENT INFORMATION WITH WRITTEN INFORMED CONSENT.] (a) Except as provided in subdivision 5, client information specified in subdivision 3, paragraph (a), may be released only with the client's or the client's legal representative's written informed consent. The written informed consent must:

(1) explain to whom the client's records may be released;

(2) explain the purpose for the release; and

(3) state an expiration date for the authorized release of the records.

(b) A social worker may provide client information specified in subdivision 3, paragraph (a), to a third party for the purpose of payment for services rendered only with the client's written informed consent.

(c) Except as provided in subdivision 5, a social worker may disclose client information specified in subdivision 3,

paragraph (a), only with the client's or the client's legal representative's written informed consent. When it is not practical to obtain written informed consent before providing necessary services, a social worker may disclose or release client information with the client's or the client's legal representative's oral informed consent.

(d) Unless otherwise authorized by law, a social worker must obtain a client's written informed consent before taking a photograph of the client or making an audio or video recording of the client, or allowing a third party to do the same. The written informed consent must explain:

(1) the purpose of the photograph or the recording and how the photograph or recording will be used, how it will be stored, and when it will be destroyed; and

(2) how the client may have access to the photograph or recording.

Subd. 5. [RELEASE OF CLIENT INFORMATION WITHOUT WRITTEN INFORMED CONSENT.] (a) A social worker may disclose client information specified in subdivision 3, paragraph (a), without the written consent of the client or the client's legal representative only under the following circumstances or under the circumstances described in paragraph (b):

(1) when mandated or authorized by federal or state law, including the mandatory reporting requirements under the duty to warn, maltreatment of minors, and vulnerable adult laws specified in section 148D.240, subdivisions 6 to 8;

(2) when the board issues a subpoena to the social worker; or

(3) when a court of competent jurisdiction orders release of the client records or information.

(b) When providing services authorized or required by law to a client who does not have the capacity to provide consent and who does not have a legal representative, a social worker must disclose or release client records or information as necessary to provide services to ensure the client's safety or to preserve the client's property or financial resources.

Subd. 6. [RELEASE OF CLIENT RECORDS OR INFORMATION.] When releasing client records or information under this section, a social worker must release current, accurate, and complete records or information.

Sec. 52. [148D.235] [FEES AND BILLING PRACTICES.]

Subdivision 1. [FEES AND PAYMENTS.] (a) A social worker must ensure that a client or a client's legal representative is informed of all fees at the initial session or meeting with the client, and that payment for services is arranged with the client or the client's legal representative at the beginning of the professional relationship. Upon request from a client or a client's legal representative, a social worker must provide in a timely manner a written payment plan or a written explanation of the charges for any services rendered.

(b) When providing services authorized or required by law to a client who does not have the capacity to provide consent and who does not have a legal representative, a social worker may submit reasonable bills to an appropriate payer for services provided.

Subd. 2. [BILLING FOR SERVICES NOT PROVIDED.] A social worker must not bill for services that have not been provided except that, with prior notice to the client, a social worker may bill for failed appointments or for cancellations without sufficient notice. A social worker may bill only for provided services which are necessary and appropriate.

Subd. 3. [NO PAYMENT FOR REFERRALS.] A social worker must not accept or give a commission, rebate, or other form of remuneration solely or primarily to profit from the referral of a client.

Subd. 4. [FEES AND BILLING PRACTICES.] A social worker must not engage in improper or fraudulent billing practices, including, but not limited to, violations of the federal Medicare and Medicaid laws or state medical assistance laws.

Sec. 53. [148D.240] [REPORTING REQUIREMENTS.]

Subdivision 1. [FAILURE TO SELF-REPORT ADVERSE ACTIONS.] The board has grounds to take action under sections

148D.255 to 148D.270 when a social worker fails to report to the board within 90 days:

(1) having been disciplined, sanctioned, or found to have violated a state, territorial, provincial, or foreign licensing agency's laws or rules;

(2) having been convicted of committing a felony, gross misdemeanor, or misdemeanor reasonably related to the practice of social work;

(3) having had a finding or verdict of guilt, whether or not the adjudication of guilt is withheld or not entered, of committing a felony, gross misdemeanor, or misdemeanor reasonably related to the practice of social work;

(4) having admitted to committing, or entering a no contest plea to committing, a felony, gross misdemeanor, or misdemeanor reasonably related to the practice of social work; or

(5) having been denied licensure by a state, territorial, provincial, or foreign licensing agency.

Subd. 2. [FAILURE TO SUBMIT APPLICATION INFORMATION.] The board has grounds to take action under sections 148D.255 to 148D.270 when an applicant or licensee fails to submit with an application the following information:

(1) the dates and dispositions of any malpractice settlements or awards made relating to the social work services provided by the applicant or licensee; or

(2) the dates and dispositions of any civil litigations or arbitrations relating to the social work services provided by the applicant or licensee.

Subd. 3. [REPORTING OTHER LICENSED HEALTH PROFESSIONALS.] An applicant or licensee must report to the appropriate health-related licensing board conduct by a licensed health professional which would constitute grounds for disciplinary action under the statutes and rules enforced by that board.

Subd. 4. [REPORTING UNLICENSED PRACTICE.] An applicant or licensee must report to the board conduct by an unlicensed person which constitutes the practice of social work, as defined

in section 148D.010, except when the unlicensed person is exempt from licensure pursuant to section 148D.065.

Subd. 5. [FAILURE TO REPORT OTHER APPLICANTS OR LICENSEES AND UNLICENSED PRACTICE.] The board has grounds to take action under sections 148D.255 to 148.270 when an applicant or licensee fails to report to the board conduct:

(1) by another licensee or applicant which the applicant or licensee has reason to believe may reasonably constitute grounds for disciplinary action under this section; or

(2) by an unlicensed person that constitutes the practice of social work when a license is required to practice social work.

Subd. 6. [DUTY TO WARN.] A licensee must comply with the duty to warn established by section 148.975.

Subd. 7. [REPORTING MALTREATMENT OF MINORS.] An applicant or licensee must comply with the reporting of maltreatment of minors established by section 626.556.

Subd. 8. [REPORTING MALTREATMENT OF VULNERABLE ADULTS.] An applicant or licensee must comply with the reporting of maltreatment of vulnerable adults established by section 626.557.

Subd. 9. [SUBPOENAS.] The board may issue subpoenas pursuant to section 148D.245 and chapter 214 for the production of any reports required by this section or any related documents.

Sec. 54. [148D.245] [INVESTIGATIVE POWERS AND PROCEDURES.]

Subdivision 1. [SUBPOENAS.] (a) The board may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material as part of its investigation of an applicant or licensee under this section or chapter 214.

(b) If any person fails or refuses to appear or testify regarding any matter about which the person may be lawfully questioned, or fails or refuses to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the board or by a subpoena of the board to do so, the board may institute a proceeding in any district court to enforce the board's order or

subpoena.

(c) The board or a designated member of the board acting on behalf of the board may issue subpoenas or administer oaths to witnesses or take affirmations. Depositions may be taken within or out of the state in the manner provided by law for the taking of depositions in civil actions.

(d) A subpoena or other process or paper may be served upon any person named therein, by mail or by any officer authorized to serve subpoenas or other process or paper in civil actions, with the same fees and mileage and in the same manner as prescribed by law for service of process issued out of the district court of this state.

(e) Fees, mileage, and other costs must be paid as the board directs.

Subd. 2. [CLASSIFICATION OF DATA.] (a) Any records obtained as part of an investigation must be treated as investigative data under section 13.41 and be classified as confidential data.

(b) Notwithstanding paragraph (a), client records must be treated as private data under chapter 13. Client records must be protected as private data in the records of the board and in administrative or judicial proceedings unless the client authorizes the board in writing to make public the identity of the client or a portion or all of the client's records.

Subd. 3. [MENTAL OR PHYSICAL EXAMINATION; CHEMICAL DEPENDENCY EVALUATION.] (a) If the board has (1) probable cause to believe that an applicant or licensee has violated a statute or rule enforced by the board, or an order issued by the board and (2) the board believes the applicant may have a health-related condition relevant to the violation, the board may issue an order directing the applicant or licensee to submit to one or more of the following: a mental examination, a physical examination, or a chemical dependency evaluation.

(b) An examination or evaluation order issued by the board must include:

(1) factual specifications on which the order is based;

(2) the purpose of the examination or evaluation;

(3) the name of the person or entity that will conduct the examination or evaluation; and

(4) the means by which the examination or evaluation will be paid for.

(c) Every applicant or licensee must submit to a mental examination, a physical examination, or a chemical dependency evaluation when ordered to do so in writing by the board.

(d) By submitting to a mental examination, a physical examination, or a chemical dependency evaluation, an applicant or licensee waives all objections to the admissibility of the examiner or evaluator's testimony or reports on the grounds that the testimony or reports constitute a privileged communication.

Subd. 4. [FAILURE TO SUBMIT TO AN EXAMINATION.] (a) If an applicant or licensee fails to submit to an examination or evaluation ordered by the board pursuant to subdivision 3, unless the failure was due to circumstances beyond the control of the applicant or licensee, the failure is an admission that the applicant or licensee violated a statute or rule enforced by the board as specified in the examination or evaluation order issued by the board. The failure may result in an application being denied or other adversarial, corrective, or disciplinary action being taken by the board without a contested case hearing.

(b) If an applicant or licensee requests a contested case hearing after the board denies an application or takes other disciplinary or adversarial action, the only issues which may be determined at the hearing are:

(1) whether the board had probable cause to issue the examination or evaluation order; and

(2) whether the failure to submit to the examination or evaluation was due to circumstances beyond the control of the applicant or licensee.

(c) Neither the record of a proceeding under this subdivision nor an order issued by the board may be admissible, subject to subpoena, or be used against the applicant or licensee in a proceeding in which the board is not a party or

decision maker.

(d) Information obtained under this subdivision must be treated as private data under chapter 13. An order issued by the board as the result of an applicant's or licensee's failure to submit to an examination or evaluation must be treated as public data under chapter 13.

Subd. 5. [ACCESS TO DATA AND RECORDS.] (a) In addition to ordering a physical or mental examination or chemical dependency evaluation, and notwithstanding section 13.384, 144.651, 595.02, or any other statute limiting access to health records, the board or a designated member of the board acting on behalf of the board may subpoena physical, mental, and chemical dependency health records relating to an applicant or licensee without the applicant's or licensee's consent if:

(1) the board has probable cause to believe that the applicant or licensee has violated chapter 214, a statute or rule enforced by the board, or an order issued by the board; and

(2) the board has reason to believe that the records are relevant and necessary to the investigation.

(b) An applicant, licensee, insurance company, government agency, health care facility, or provider as defined in section 144.335, subdivision 1, paragraph (b), must comply with any subpoena of the board under this subdivision and is not liable in any action for damages for releasing information subpoenaed by the board under this subdivision unless the information provided is false and the person or entity providing the information knew or had reason to know that the information was false.

(c) Information on individuals obtained under this subdivision must be treated as investigative data under section 13.41 and be classified as confidential data.

(d) If an applicant, licensee, person, or entity does not comply with any subpoena of the board under this subdivision, the board may institute a proceeding in any district court to enforce the board's subpoena.

Subd. 6. [EVIDENCE OF PAST SEXUAL CONDUCT.] If, in a

proceeding for taking action against an applicant or licensee under this section, the charges involve sexual contact with a client or former client, the board or administrative law judge must not consider evidence of the client's or former client's previous sexual conduct. Reference to the client's or former client's previous sexual conduct must not be made during the proceedings or in the findings, except by motion of the complainant, unless the evidence would be admissible under the applicable provisions of section 609.347, subdivision 3.

Subd. 7. [INVESTIGATIONS INVOLVING VULNERABLE ADULTS OR CHILDREN IN NEED OF PROTECTION.] (a) Except as provided in paragraph (b), if the board receives a complaint about a social worker regarding the social worker's involvement in a case of vulnerable adults or children in need of protection, the county or other appropriate public authority may request that the board suspend its investigation, and the board must comply until such time as the court issues its findings on the case.

(b) Notwithstanding paragraph (a), the board may continue with an investigation if the board determines that doing so is in the best interests of the vulnerable adult or child and is consistent with the board's obligation to protect the public. If the board chooses to continue an investigation, the board must notify the county or other appropriate public authority in writing and state its reasons for doing so.

Subd. 8. [NOTIFICATION OF COMPLAINANT.] (a) In no more than 14 calendar days after receiving a complaint regarding a licensee, the board must notify the complainant that the board has received the complaint.

(b) The board must periodically notify the complainant of the status of the complaint.

Subd. 9. [NOTIFICATION OF LICENSEE.] (a) Except as provided in paragraph (b), in no more than 60 calendar days after receiving a complaint regarding a licensee, the board must notify the licensee that the board has received the complaint and inform the licensee of:

(1) the substance of the complaint;

(2) the sections of the law that allegedly have been violated; and

(3) whether an investigation is being conducted.

(b) Paragraph (a) does not apply if:

(1) the board determines that such notice would compromise the board's investigation pursuant to section 214.10; or

(2) the board determines that such notice cannot reasonably be accomplished within this time.

(c) The board must periodically notify the licensee of the status of the complaint.

Subd. 10. [RESOLUTION OF COMPLAINTS.] In no more than one year after receiving a complaint regarding a licensee, the board must resolve or dismiss the complaint unless the board determines that resolving or dismissing the complaint cannot reasonably be accomplished within this time.

Sec. 55. [148D.250] [OBLIGATION TO COOPERATE.]

Subdivision 1. [OBLIGATION TO COOPERATE.] An applicant or licensee who is the subject of an investigation, or who is questioned by or on behalf of the board in connection with an investigation, must cooperate fully with the investigation. Cooperation includes, but is not limited to:

(1) responding fully and promptly to any question relating to the investigation;

(2) as reasonably requested by the board, providing copies of client and other records in the applicant's or licensee's possession relating to the investigation;

(3) executing release of records as reasonably requested by the board; and

(4) appearing at conferences, hearings, or meetings scheduled by the board, as required in sections 148D.255 to 148D.270 and chapter 214.

Subd. 2. [INVESTIGATION.] A social worker must not knowingly withhold relevant information, give false or misleading information, or do anything to obstruct an investigation of the social worker or another social worker by the board or by another state or federal regulatory or law

enforcement authority.

Subd. 3. [PAYMENT FOR COPIES.] The board must pay for copies requested by the board.

Subd. 4. [ACCESS TO CLIENT RECORDS.] Notwithstanding any law to the contrary, an applicant or licensee must allow the board access to any records of a client provided services by the applicant or licensee under investigation. If the client has not signed a consent permitting access to the client's records, the applicant or licensee must delete any data in the records that identifies the client before providing the records to the board.

Subd. 5. [CLASSIFICATION OF DATA.] Any records obtained pursuant to this subdivision must be treated as investigative data pursuant to section 13.41 and be classified as confidential data.

Sec. 56. [148D.255] [TYPES OF ACTIONS.]

Subdivision 1. [ACTIONS.] The board may take disciplinary action pursuant to section 148D.260, adversarial but nondisciplinary action pursuant to section 148D.265, or voluntary action pursuant to section 148D.270. Any action taken under sections 148D.260 to 148D.270 is public data.

Subd. 2. [DISCIPLINARY ACTION.] For purposes of section 148D.260, "disciplinary action" means an action taken by the board against an applicant or licensee that addresses a complaint alleging a violation of a statute or rule the board is empowered to enforce.

Subd. 3. [ADVERSARIAL BUT NONDISCIPLINARY ACTION.] For purposes of section 148D.265, "adversarial but nondisciplinary action" means a nondisciplinary action taken by the board that addresses a complaint alleging a violation of a statute or rule the board is empowered to enforce.

Subd. 4. [VOLUNTARY ACTION.] For purposes of section 148D.270, "voluntary action" means a nondisciplinary action agreed to by the board or a designated board member and an applicant or licensee that, through educational or other corrective means, addresses a complaint alleging a violation of

a statute or rule that the board is empowered to enforce.

Sec. 57. [148D.260] [DISCIPLINARY ACTIONS.]

Subdivision 1. [GENERAL DISCIPLINARY ACTIONS.] (a) When the board has grounds for disciplinary actions under this chapter, the board may take one or more of the following disciplinary actions:

(1) deny an application;

(2) permanently revoke a license to practice social work;

(3) indefinitely or temporarily suspend a license to practice social work;

(4) impose restrictions on a licensee's scope of practice;

(5) impose conditions required for the licensee to maintain licensure, including, but not limited to, additional education, supervision, and requiring the passing of an examination provided for in section 148D.055;

(6) reprimand a licensee;

(7) impose a civil penalty of up to $10,000 for each violation in order to discourage future violations or to deprive the licensee of any economic advantage gained by reason of the violation; or

(8) impose a fee to reimburse the board for all or part of the cost of the proceedings resulting in disciplinary action, including, but not limited to, the amount paid by the board for services received from or expenses incurred by the Office of Administrative Hearings, the Office of the Attorney General, court reporters, witnesses, board members, board staff, or the amount paid by the board for reproducing records.

(b) Disciplinary action taken by the board under this subdivision is in effect pending determination of an appeal unless the court, upon petition and for good cause shown, decides otherwise.

Subd. 2. [REPRIMANDS.] (a) In addition to the board's authority to issue a reprimand pursuant to subdivision 1, a designated board member reviewing a complaint as provided for in chapter 214 may issue a reprimand to a licensee. The designated board member must notify the licensee that the reprimand will

become final disciplinary action unless the licensee requests a hearing by the board within 14 calendar days.

(b) If the licensee requests a hearing within 14 calendar days, the board must schedule a hearing unless the designated board member withdraws the reprimand.

(c) The hearing must be scheduled within 14 working days of the time the licensee submits a request for the hearing.

(d) The designated board member who issued the reprimand may participate in the hearing but must not deliberate or vote on the decision by the board.

(e) The only evidence permitted at the hearing is affidavits or other documents except for testimony by the licensee or other witnesses whose testimony the board chair has authorized for good cause.

(f) If testimony is authorized, the testimony is subject to cross-examination.

(g) After the hearing, the board must affirm or dismiss the reprimand.

Subd. 3. [TEMPORARY SUSPENSIONS.] (a) In addition to any other remedy provided by statute, the board or a designated board member may, without a hearing, temporarily suspend a license to practice social work if the board or the designated board member finds that:

(1) the licensee has violated a statute or rule enforced by the board, any other federal or state law or rule related to the practice of social work, or an order, stipulation, or agreement agreed to or issued by the board; and

(2) continued practice by the licensee would create a serious risk of harm to others.

(b) The suspension is in effect upon service of a written order on the licensee specifying the statute, rule, order, stipulation, or agreement violated. Service of the order is effective if the order is served on the licensee or the licensee's attorney personally or by first class mail to the most recent address provided to the board for the licensee or the licensee's attorney.

(c) The temporary suspension remains in effect until after the board issues an order pursuant to paragraph (e), or if there is a contested case hearing, after the board issues a written final order pursuant to paragraph (g).

(d) If the licensee requests in writing within five calendar days of service of the order that the board hold a hearing, the board must hold a hearing on the sole issue of whether to continue, modify, or lift the suspension. The board must hold the hearing within ten working days of receipt of the licensee's written request. Evidence presented by the board or licensee must be in affidavit form only, except that the licensee or the licensee's attorney may present oral argument.

(e) Within five working days after the hearing, the board must issue its order. If the licensee contests the order, the board must schedule a contested case hearing under chapter 14. The contested case hearing must be scheduled to occur within 45 calendar days after issuance of the order.

(f) The administrative law judge must issue a report within 30 calendar days after the contested case hearing is concluded.

(g) The board must issue a final order within 30 calendar days after the board receives the administrative law judge's report.

Sec. 58. [148D.265] [ADVERSARIAL BUT NONDISCIPLINARY ACTIONS.]

Subdivision 1. [AUTOMATIC SUSPENSIONS.] (a) A license to practice social work is automatically suspended if:

(1) a guardian of a licensee is appointed by order of a court pursuant to sections 524.5-101 and 524.5.102; or

(2) the licensee is committed by order of a court pursuant to chapter 253B.

(b) A license remains suspended until:

(1) the licensee is restored to capacity by a court; and

(2) upon petition by the licensee and after a hearing or an agreement with the licensee, the board terminates the suspension.

(c) If the board terminates the suspension, it may do so with or without conditions or restrictions, including, but not

limited to, participation in the health professional services program.

Subd. 2. [CEASE AND DESIST ORDERS.] (a) The board or a designated board member may issue a cease and desist order to stop a person from engaging in unauthorized practice or from violating or threatening to violate a statute or rule enforced by the board or an order, stipulation, or agreement agreed to or issued by the board.

(b) The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If the person fails to request a hearing in writing postmarked within 15 calendar days after service of the cease and desist order, the order is the final order of the board and is not reviewable by a court or agency.

(c) If the board receives a written request for a hearing postmarked within 15 calendar days after service of the cease and desist order, the board must schedule a hearing within 30 calendar days of receiving the request.

(d) The administrative law judge must issue a report within 30 calendar days after the contested case hearing is concluded.

(e) Within 30 calendar days after the board receives the administrative law judge's report, the board must issue a final order modifying, vacating, or making permanent the cease and desist order. The final order remains in effect until modified or vacated by the board.

(f) If a person does not comply with a cease and desist order, the board may institute a proceeding in any district court to obtain injunctive relief or other appropriate relief, including but not limited to, a civil penalty payable to the board of up to $10,000 for each violation.

(g) A cease and desist order issued pursuant to this subdivision does not relieve a person from criminal prosecution by a competent authority or from disciplinary action by the board.

Subd. 3. [INJUNCTIVE RELIEF.] (a) In addition to any other

remedy provided by law, the board may bring an action in district court for injunctive relief to restrain any unauthorized practice or violation or threatened violation of any statute or rule, stipulation, or agreement agreed to or enforced by the board or an order issued by the board.

(b) A temporary restraining order may be granted in the proceeding if continued activity by a person would create an imminent risk of harm to others.

(c) Injunctive relief granted pursuant to this subdivision does not relieve a person from criminal prosecution by a competent authority or from disciplinary action by the board.

(d) In bringing an action for injunctive relief, the board need not show irreparable harm.

Sec. 59. [148D.270] [VOLUNTARY ACTIONS.]

Subdivision 1. [AGREEMENTS FOR CORRECTIVE ACTION.] (a) The board or a designated board member may enter into an agreement for corrective action with an applicant or licensee when the board or a designated board member determines that a complaint alleging a violation of a statute or rule enforced by the board or an order issued by the board may best be resolved through an agreement for corrective action when disciplinary action is not required to protect the public.

(b) An agreement for corrective action must:

(1) be in writing;

(2) specify the facts upon which the agreement is based;

(3) clearly indicate the corrective action agreed upon; and

(4) provide that the complaint that resulted in the agreement must be dismissed by the board or the designated board member upon successful completion of the corrective action.

(c) The board or designated board member may determine successful completion when the applicant or licensee submits a request for dismissal that documents the applicant's or licensee's successful completion of the corrective action. The burden of proof is on the applicant or licensee to prove successful completion.

(d) An agreement for corrective action is not disciplinary

action but must be treated as public data under chapter 13.

(e) The board may impose a fee to reimburse the board for all or part of the costs of the proceedings resulting in a corrective action, including, but not limited to, the amount paid by the board for services received from or expenses incurred by the Office of the Attorney General, board members, board staff, or the amount paid by the board for reproducing records.

(f) The board or designated board member must not enter into an agreement for corrective action when the complaint alleged sexual conduct with a client unless there is insufficient evidence to justify disciplinary action but there is a basis for corrective action.

Subd. 2. [STIPULATIONS TO CEASE PRACTICING SOCIAL WORK.] (a) The board or a designated board member may enter into a stipulation to cease practicing social work with a licensee if the board or designated board member determines that the licensee is unable to practice social work competently or safely or that the social worker's continued practice creates an unacceptable risk of safety to clients, potential clients, or the public.

(b) A stipulation to cease practicing social work must:

(1) be in writing;

(2) specify the facts upon which the stipulation is based;

(3) clearly indicate that the licensee must not practice social work and must not hold out to the public that the social worker is licensed; and

(4) specify the term of the stipulation or when and under what circumstances the licensee may petition the board for termination of the stipulation.

(c) A stipulation to cease practicing social work is not disciplinary action but must be treated as public data under chapter 13.

(d) Nothing in this subdivision prevents the board or designated board member from taking any other disciplinary or adversarial action authorized by sections 148D.255 to 148D.265

in lieu of or in addition to entering into a stipulation to cease practicing social work.

Sec. 60. [148D.275] [UNAUTHORIZED PRACTICE.]

No individual may:

(1) engage in the practice of social work without a social work license under sections 148D.055 and 148D.060, except when the individual is exempt from licensure pursuant to section 148D.065;

(2) provide social work services to a client who resides in this state when the individual providing the services is not licensed as a social worker pursuant to sections 148D.055 to 148D.060, except when the individual is exempt from licensure pursuant to section 148D.065.

Sec. 61. [148D.280] [USE OF TITLES.]

No individual may be presented to the public by any title incorporating the words "social work" or "social worker" or in the titles in section 148D.195, unless that individual holds a license pursuant to sections 148D.055 and 148D.060, or practices in a setting exempt from licensure pursuant to section 148D.065.

Sec. 62. [148D.285] [REPORTING REQUIREMENTS.]

Subdivision 1. [INSTITUTIONS.] A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization must report to the board:

(1) any adversarial action, disciplinary action, or other sanction for conduct that might constitute grounds for action under section 148D.190;

(2) the resignation of any applicant or licensee prior to the conclusion of any proceeding for adversarial action, disciplinary action, or other sanction for conduct that might constitute grounds for action under section 148D.190; or

(3) the resignation of any applicant or licensee prior to the commencement of a proceeding for adversarial action, disciplinary action, or other sanction for conduct that might constitute grounds for action under section 148D.190, but after the applicant or licensee had knowledge that a proceeding was

contemplated or in preparation.

Subd. 2. [PROFESSIONAL SOCIETIES AND ASSOCIATIONS.] A state or local professional society or association whose members consist primarily of licensed social workers must report to the board any adversarial action, disciplinary action, or other sanction taken against a member.

Subd. 3. [IMMUNITY.] An individual, professional society or association, state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, other health care institution or organization or other entity is immune from civil liability or criminal prosecution for submitting in good faith a report under subdivision 1 or 2 or for otherwise reporting, providing information, or testifying about violations or alleged violations of this chapter.

Sec. 63. [148D.290] [PENALTIES.]

An individual or other entity that violates section 148D.275, 148D.280, or 148D.285 is guilty of a misdemeanor.

Sec. 64. Minnesota Statutes 2004, section 214.01, subdivision 2, is amended to read:

Subd. 2. [HEALTH-RELATED LICENSING BOARD.] "Health-related licensing board" means the Board of Examiners of Nursing Home Administrators established pursuant to section 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice established pursuant to section 146A.02, the Board of Medical Practice created pursuant to section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry established pursuant to section 148.52, the Board of Physical Therapy established pursuant to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board of Social Work pursuant to section ~~148B.19~~ 148D.025, the Board of Marriage and Family Therapy pursuant to section 148B.30, the Office of Mental Health Practice established pursuant to section 148B.61, the Board of Behavioral Health and Therapy established by section 148B.51, the Alcohol

and Drug Counselors Licensing Advisory Council established pursuant to section 148C.02, the Board of Dietetics and Nutrition Practice established under section 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established pursuant to section 153.02, and the Board of Veterinary Medicine, established pursuant to section 156.01.

Sec. 65. Minnesota Statutes 2004, section 245.462, subdivision 18, is amended to read:

Subd. 18. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:

(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or

(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under ~~section 148B.21, subdivision~~ 6 chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147

and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 66. Minnesota Statutes 2004, section 245.4871, subdivision 27, is amended to read:

Subd. 27. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under ~~section 148B.21, subdivision 6~~ chapter 148D, or a person with a master's degree in social work from an accredited

college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 67. Minnesota Statutes 2004, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. [PAYMENTS FOR MENTAL HEALTH SERVICES.] Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. For purposes of reimbursement of mental health professionals under the medical assistance program, all social workers who:

(1) have received a master's degree in social work from a program accredited by the Council on Social Work Education;

(2) are licensed at the level of graduate social worker or independent social worker; and

(3) are practicing clinical social work under appropriate supervision, as defined by ~~section 148B.18~~ chapter 148D; meet all requirements under Minnesota Rules, part 9505.0323, subpart 24, and shall be paid accordingly.

Sec. 68. Minnesota Statutes 2004, section 256J.08, subdivision 73a, is amended to read:

Subd. 73a. [QUALIFIED PROFESSIONAL.] (a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, a physician's assistant, a nurse practitioner, or a licensed chiropractor.

(b) For mental retardation and intelligence testing, a "qualified professional" means an individual qualified by training and experience to administer the tests necessary to make determinations, such as tests of intellectual functioning, assessments of adaptive behavior, adaptive skills, and developmental functioning. These professionals include licensed psychologists, certified school psychologists, or certified psychometrists working under the supervision of a licensed psychologist.

(c) For learning disabilities, a "qualified professional" means a licensed psychologist or school psychologist with experience determining learning disabilities.

(d) For mental health, a "qualified professional" means a licensed physician or a qualified mental health professional. A "qualified mental health professional" means:

(1) for children, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at

least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) for adults, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in clinical social work, a person licensed as an independent clinical social worker under ~~section 148B.21, subdivision 6~~ chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(4) in psychology, an individual licensed by the Board of Psychology under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(5) in psychiatry, a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; and

(6) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 69. Minnesota Statutes 2004, section 319B.02, subdivision 19, is amended to read:

Subd. 19. [PROFESSIONAL SERVICES.] "Professional services" means services of the type required or permitted to be furnished by a professional under a license, registration, or certificate

issued by the state of Minnesota to practice medicine and surgery under sections 147.01 to 147.22, as a physician assistant pursuant to sections 147A.01 to 147A.27, chiropractic under sections 148.01 to 148.105, registered nursing under sections 148.171 to 148.285, optometry under sections 148.52 to 148.62, psychology under sections 148.88 to 148.98, social work under ~~sections 148B.18 to 148B.289~~ chapter 148D, dentistry and dental hygiene under sections 150A.01 to 150A.12, pharmacy under sections 151.01 to 151.40, podiatric medicine under sections 153.01 to 153.25, veterinary medicine under sections 156.001 to 156.14, architecture, engineering, surveying, landscape architecture, geoscience, and certified interior design under sections 326.02 to 326.15, accountancy under chapter 326A, or law under sections 481.01 to 481.17, or under a license or certificate issued by another state under similar laws. Professional services includes services of the type required to be furnished by a professional pursuant to a license or other authority to practice law under the laws of a foreign nation.

Sec. 70. Minnesota Statutes 2004, section 319B.40, is amended to read:

319B.40 [PROFESSIONAL HEALTH SERVICES.]

(a) Individuals who furnish professional services pursuant to a license, registration, or certificate issued by the state of Minnesota to practice medicine pursuant to sections 147.01 to 147.22, as a physician assistant pursuant to sections 147A.01 to 147A.27, chiropractic pursuant to sections 148.01 to 148.106, registered nursing pursuant to sections 148.171 to 148.285, optometry pursuant to sections 148.52 to 148.62, psychology pursuant to sections 148.88 to 148.98, social work pursuant to ~~sections 148B.18 to 148B.289~~ chapter 148D, dentistry pursuant to sections 150A.01 to 150A.12, pharmacy pursuant to sections 151.01 to 151.40, or podiatric medicine pursuant to sections 153.01 to 153.26 are specifically authorized to practice any of these categories of services in combination if the individuals are organized under this chapter.

(b) This authorization does not authorize an individual to

practice any profession, or furnish a professional service, for which the individual is not licensed, registered, or certified, but otherwise applies regardless of any contrary provision of a licensing statute or rules adopted pursuant to that statute, related to practicing and organizing in combination with other health services professionals.

Sec. 71. [REPEALER.]

Subdivision 1. [REPEAL OF STATUTES.] Minnesota Statutes 2004, sections 148B.18; 148B.185; 148B.19; 148B.20; 148B.21; 148B.215; 148B.22; 148B.224; 148B.225; 148B.226; 148B.24; 148B.25; 148B.26; 148B.27; 148B.28; 148B.281; 148B.282; 148B.283; 148B.284; 148B.285; 148B.286; 148B.287; 148B.288; and 148B.289, are repealed.

Subd. 2. [REPEAL OF RULES.] Minnesota Rules, parts 8740.0100; 8740.0110; 8740.0120; 8740.0122; 8740.0130; 8740.0155; 8740.0185; 8740.0187; 8740.0200; 8740.0240; 8740.0260; 8740.0285; 8740.0300; 8740.0310; 8740.0315; 8740.0320; 8740.0325; 8740.0330; 8740.0335; 8740.0340; and 8740.0345, are repealed.

Sec. 72. [EFFECTIVE DATE.]

This article is effective January 1, 2006.

ARTICLE 2

BOARD OF PHYSICAL THERAPY

Section 1. Minnesota Statutes 2004, section 148.65, is amended by adding a subdivision to read:

Subd. 3. [PHYSICAL THERAPIST ASSISTANT.] "Physical therapist assistant" means a graduate of a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) or a recognized comparable national accrediting agency approved by the board. The physical therapist assistant, under the direction and supervision of the physical therapist, performs physical therapy interventions and assists with coordination, communication, and documentation; and patient-client-related instruction. The physical therapist is not required to be on-site except as required under Minnesota Rules, part

5601.1500, but must be easily available by telecommunications.

Sec. 2. Minnesota Statutes 2004, section 148.65, is amended by adding a subdivision to read:

Subd. 4. [PHYSICAL THERAPY AIDE.] "Physical therapy aide" means a person, working under the direct supervision of a physical therapist, who is not a physical therapist assistant as defined in subdivision 3, who performs tasks as provided under Minnesota Rules, part 5601.1400.

Sec. 3. Minnesota Statutes 2004, section 148.65, is amended by adding a subdivision to read:

Subd. 5. [STUDENT PHYSICAL THERAPIST.] "Student physical therapist" means a person in a professional educational program, approved by the board under section 148.705, who is satisfying supervised clinical education requirements by performing physical therapy under the on-site supervision of a licensed physical therapist. "On-site supervision" means the physical therapist is easily available for instruction to the student physical therapist. The physical therapist shall have direct contact with the patient during at least every second treatment session by the student physical therapist. Telecommunications, except within the facility, does not meet the requirement of on-site supervision.

Sec. 4. Minnesota Statutes 2004, section 148.65, is amended by adding a subdivision to read:

Subd. 6. [STUDENT PHYSICAL THERAPIST ASSISTANT.] "Student physical therapist assistant" means a person in a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) or a recognized comparable national accrediting agency approved by the board. The student physical therapist assistant, under the direct supervision of the physical therapist, or the direct supervision of the physical therapist and physical therapist assistant, performs physical therapy interventions and assists with coordination, communication, documentation, and patient-client-related instruction. "Direct supervision" means the physical therapist is physically present

and immediately available to provide instruction to the student physical therapist assistant.

Sec. 5. Minnesota Statutes 2004, section 148.65, is amended by adding a subdivision to read:

Subd. 7. [SUPPORTIVE PERSONNEL.] "Supportive personnel" means a physical therapist assistant and a physical therapy aide.

Sec. 6. Minnesota Statutes 2004, section 148.706, is amended to read:

148.706 [SUPERVISION OF ASSISTANTS ~~AND~~, AIDES, AND STUDENTS.]

Every physical therapist who uses the services of ~~an~~ a physical therapist assistant or physical therapy aide for the purpose of assisting in the practice of physical therapy is responsible for functions performed by the assistant or aide while engaged in such assistance. The physical therapist shall ~~permit-the-assistant-or-aide-to-perform-only-those-functions which-the-therapist-is-authorized-by-rule-to-delegate-to-a physical-therapist-assistant-or-assign-to-a-physical-therapy aide-and-shall-provide-supervision-as-specified~~ delegate duties to the physical therapist assistant and assign tasks to the physical therapy aide in accordance with Minnesota Rules, part 5601.1400. Physical therapists who instruct student physical therapists and student physical therapist assistants are responsible for the functions performed by the students and shall supervise the students as provided under section 148.65, subdivisions 5 and 6.

Sec. 7. [148.735] [CANCELLATION OF LICENSE IN GOOD STANDING.]

Subdivision 1. [BOARD APPROVAL; REPORTING.] A physical therapist holding an active license to practice physical therapy in the state may, upon approval of the board, be granted license cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the person. Such action by the board shall be reported as a cancellation of a license in good standing.

Subd. 2. [FEES NONREFUNDABLE.] A physical therapist who receives board approval for license cancellation is not entitled to a refund of any license fees paid for the licensure year in which cancellation of the license occurred.

Subd. 3. [NEW LICENSE AFTER CANCELLATION.] If a physical therapist who has been granted board approval for license cancellation desires to resume the practice of physical therapy in Minnesota, that physical therapist must obtain a new license by applying for licensure and fulfilling the requirements then in existence for obtaining an initial license to practice physical therapy in Minnesota.

Sec. 8. [148.736] [CANCELLATION OF CREDENTIALS UNDER DISCIPLINARY ORDER.]

Subdivision 1. [BOARD APPROVAL; REPORTING.] A physical therapist, whose right to practice is under suspension, condition, limitation, qualification, or restriction by the board may be granted cancellation of credentials by approval of the board. Such action by the board shall be reported as cancellation while under discipline. Credentials, for purposes of this section, means board authorized documentation of the privilege to practice physical therapy.

Subd. 2. [FEES NONREFUNDABLE.] A physical therapist who receives board approval for credential cancellation is not entitled to a refund of any fees paid for the credentialing year in which cancellation of the credential occurred.

Subd. 3. [NEW CREDENTIAL AFTER CANCELLATION.] If a physical therapist who has been granted board approval for credential cancellation desires to resume the practice of physical therapy in Minnesota, that physical therapist must obtain a new credential by applying to the board and fulfilling the requirements then in existence for obtaining an initial credential to practice physical therapy in Minnesota.

Sec. 9. [148.737] [CANCELLATION OF LICENSE FOR NONRENEWAL.]

The Board of Physical Therapy shall not renew, reissue, reinstate, or restore a license that has lapsed on or after

January 1, 2006, and has not been renewed within two annual license renewal cycles starting January 1, 2008. A licensee whose license is canceled for nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements then in existence for an initial license to practice physical therapy in Minnesota.

Sec. 10. Minnesota Statutes 2004, section 148.75, is amended to read:

148.75 [LICENSES; DENIAL, SUSPENSION, REVOCATION.]

(a) The state Board of Physical Therapy may refuse to grant a license to any physical therapist, or may suspend or revoke the license of any physical therapist for any of the following grounds:

(1) using drugs or intoxicating liquors to an extent which affects professional competence;

(2) conviction of a felony;

(3) conviction for violating any state or federal narcotic law;

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

(5) conduct unbecoming a person licensed as a physical therapist or conduct detrimental to the best interests of the public;

(6) gross negligence in the practice of physical therapy as a physical therapist;

(7) treating human ailments by physical therapy after an initial 30-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state in the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, the practice of podiatry as defined in section 153.01, or the practice of dentistry as defined in section 150A.05 and whose license is in good standing; or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by board of physical therapy rule;

(8) treating human ailments, without referral, by physical therapy treatment without first having practiced one year under a physician's orders as verified by the board's records;

(9) failing to consult with the patient's health care provider who prescribed the physical therapy treatment if the treatment is altered by the physical therapist from the original written order. The provision does not include written orders to "evaluate and treat";

(10) treating human ailments other than by physical therapy unless duly licensed or registered to do so under the laws of this state;

(11) inappropriate delegation to a physical therapist assistant or inappropriate task assignment to an aide or inadequate supervision of ~~either level of supportive personnel~~ a student physical therapist, physical therapist assistant, student physical therapist assistant, or a physical therapy aide;

(12) practicing as a physical therapist performing medical diagnosis, the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01;

(13) failing to comply with a reasonable request to obtain appropriate clearance for mental or physical conditions that would interfere with the ability to practice physical therapy, and that may be potentially harmful to patients;

(14) dividing fees with, or paying or promising to pay a commission or part of the fee to, any person who contacts the physical therapist for consultation or sends patients to the physical therapist for treatment;

(15) engaging in an incentive payment arrangement, other than that prohibited by clause (14), that tends to promote physical therapy overuse, that allows the referring person or person who controls the availability of physical therapy services to a client to profit unreasonably as a result of patient treatment;

(16) practicing physical therapy and failing to refer to a

licensed health care professional a patient whose medical condition at the time of evaluation has been determined by the physical therapist to be beyond the scope of practice of a physical therapist; ~~and~~

(17) failing to report to the board other licensed physical therapists who violate this section; and

(18) practice of physical therapy under lapsed or nonrenewed credentials.

(b) A license to practice as a physical therapist is suspended if (1) a guardian of the physical therapist is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the physical therapist; or (2) the physical therapist is committed by order of a court pursuant to chapter 253B. The license remains suspended until the physical therapist is restored to capacity by a court and, upon petition by the physical therapist, the suspension is terminated by the Board of Physical Therapy after a hearing.

Sec. 11. [148.754] [EXAMINATION; ACCESS TO MEDICAL DATA.]

(a) If the board has probable cause to believe that a physical therapist comes under section 148.75, paragraph (a), it may direct the physical therapist to submit to a mental or physical examination. For the purpose of this paragraph, every physical therapist is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that they constitute a privileged communication. Failure of the physical therapist to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A physical therapist affected under this paragraph shall, at reasonable intervals, be given an opportunity to demonstrate that the person can resume

the competent practice of physical therapy with reasonable skill and safety to the public.

(b) In any proceeding under paragraph (a), neither the record of proceedings nor the orders entered by the board shall be used against a physical therapist in any other proceeding.

(c) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a physical therapist or applicant without the person's or applicant's consent if the board has probable cause to believe that a physical therapist comes under paragraph (a). The medical data may be requested from a provider, as defined in section 144.335, subdivision 1, paragraph (b), an insurance company, or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this paragraph and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this paragraph, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this paragraph is classified as private under sections 13.01 to 13.87.

Sec. 12. [148.755] [TEMPORARY SUSPENSION OF LICENSE.]

In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a physical therapist if the board finds that the physical therapist has violated a statute or rule which the board is empowered to enforce and continued practice by the physical therapist would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the physical therapist, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a

disciplinary hearing to be held pursuant to the Administrative Procedure Act, chapter 14. The physical therapist shall be provided with at least 20 days' notice of any hearing held pursuant to this section. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

Sec. 13. [LICENSE ISSUANCE.]

Notwithstanding Minnesota Statutes, sections 148.65 to 148.78, the Board of Physical Therapy shall grant a physical therapist license to an individual who has been issued physical therapy licenses between 1980 and 1995 in at least three other states and at least one foreign country and who applies before August 1, 2005.

Sec. 14. [REPEALER.]

Minnesota Rules, part 5601.0100, subparts 3 and 4, are repealed.

ARTICLE 3

BOARD OF PSYCHOLOGY

Section 1. Minnesota Statutes 2004, section 148.89, subdivision 5, is amended to read:

Subd. 5. [PRACTICE OF PSYCHOLOGY.] "Practice of psychology" means the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, or procedures for any reason, including to prevent, eliminate, or manage symptomatic, maladaptive, or undesired behavior and to enhance interpersonal relationships, work, life and developmental adjustment, personal and organizational effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, the following services, regardless of whether the provider receives payment for the services:

(1) psychological research and teaching of psychology;

(2) assessment, including psychological testing and other means of evaluating personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and

neuropsychological functioning;

(3) a psychological report, whether written or oral, including testimony of a provider as an expert witness, concerning the characteristics of an individual or entity;

(4) psychotherapy, including but not limited to, categories such as behavioral, cognitive, emotive, systems, psychophysiological, or insight-oriented therapies; counseling; hypnosis; and diagnosis and treatment of:

(i) mental and emotional disorder or disability;

(ii) alcohol and substance dependence or abuse;

(iii) disorders of habit or conduct;

(iv) the psychological aspects of physical illness or condition, accident, injury, or disability;

(v) life adjustment issues, including work-related and bereavement issues; and

(vi) child, family, or relationship issues;

(5) psychoeducational services and treatment; and

(6) consultation and supervision.

Sec. 2. Minnesota Statutes 2004, section 148.90, subdivision 1, is amended to read:

Subdivision 1. [BOARD OF PSYCHOLOGY.] (a) The Board of Psychology is created with the powers and duties described in this section. The board has 11 members who consist of:

(1) three ~~persons~~ individuals licensed as licensed psychologists who have ~~a~~ doctoral ~~degree~~ degrees in psychology;

(2) two ~~persons~~ individuals licensed as licensed psychologists who have ~~a~~ master's ~~degree~~ degrees in psychology;

(3) two psychologists, not necessarily licensed, one with a doctoral degree in psychology who represents a doctoral training program in psychology, and one who represents a master's degree training program in psychology;

(4) one ~~person~~ individual licensed or qualified to be licensed as: (i) through December 31, 2010, a licensed psychological practitioner; and (ii) after December 31, 2010, a licensed psychologist; and

(5) three public members.

(b) After the date on which fewer than 30 percent of the ~~persons~~ individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), ~~the first vacancy~~ vacancies filled under paragraph (a), clause (2), shall be filled by ~~a person~~ an individual with either a master's or doctoral degree in psychology licensed or qualified to be licensed as a licensed ~~psychological practitioner. From this date on, this position when vacant shall be filled by a person licensed or qualified to be licensed as a licensed psychological practitioner~~ psychologist.

(c) After the date on which fewer than 15 percent of the ~~persons~~ individuals licensed by the board as licensed psychologists qualify for licensure under section 148.907, subdivision 3, paragraph (b), ~~the first vacancy~~ vacancies under paragraph (a), clause (2), ~~for a licensed psychologist~~ shall be filled by an individual with either a master's or doctoral degree in psychology ~~shall be filled by a~~ licensed or qualified to be licensed as a licensed psychologist. ~~From this date on, this position when vacant shall be filled by a person licensed as a licensed psychologist.~~

Sec. 3. Minnesota Statutes 2004, section 148.907, is amended by adding a subdivision to read:

Subd. 5. [CONVERTING FROM A LICENSED PSYCHOLOGICAL PRACTITIONER TO A LICENSED PSYCHOLOGIST.] Notwithstanding subdivision 3, to convert from licensure as a licensed psychological practitioner to licensure as a licensed psychologist, a licensed psychological practitioner shall have:

(1) completed an application provided by the board for conversion from licensure as a licensed psychological practitioner to licensure as a licensed psychologist;

(2) paid a nonrefundable fee of $500;

(3) documented successful completion of two full years, or the equivalent, of supervised postlicensure employment meeting the requirements of section 148.925, subdivision 5, as it relates to preparation for licensure as a licensed psychologist

as follows:

(i) for individuals licensed as licensed psychological practitioners on or before December 31, 2006, the supervised practice must be completed by December 31, 2010; and

(ii) for individuals licensed as licensed psychological practitioners after December 31, 2006, the supervised practice must be completed within four years from the date of licensure; and

(4) no unresolved disciplinary action or complaints pending, or incomplete disciplinary orders or corrective action agreements in Minnesota or any other jurisdiction.

Sec. 4. Minnesota Statutes 2004, section 148.908, subdivision 2, is amended to read:

Subd. 2. [REQUIREMENTS FOR LICENSURE AS A LICENSED PSYCHOLOGICAL PRACTITIONER.] To become licensed by the board as a licensed psychological practitioner, an applicant shall comply with the following requirements:

(1) ~~pass an examination in psychology;~~

~~(2) pass a professional responsibility examination on the practice of psychology;~~

~~(3) pass any other examinations as required by board rules;~~

~~(4) pay nonrefundable fees to the board for applications, processing, testing, renewals, and materials;~~

~~(5) have attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction; and~~

~~(6)~~ have earned a doctoral or master's degree or the equivalent of a master's degree in a doctoral program with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule. The degree requirements must be completed by December 31, 2005;

(2) complete an application for admission to the examination for professional practice in psychology and pay the nonrefundable application fee by December 31, 2005;

(3) complete an application for admission to the professional responsibility examination and pay the nonrefundable application fee by December 31, 2005;

(4) pass the examination for professional practice in psychology by December 31, 2006;

(5) pass the professional responsibility examination by December 31, 2006;

(6) complete an application for licensure as a licensed psychological practitioner and pay the nonrefundable application fee by March 1, 2007; and

(7) have attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction.

Sec. 5. Minnesota Statutes 2004, section 148.908, is amended by adding a subdivision to read:

Subd. 3. [TERMINATION OF LICENSURE.] Effective December 31, 2011, the licensure of all licensed psychological practitioners shall be terminated without further notice and licensure as a licensed psychological practitioner in Minnesota shall be eliminated.

Sec. 6. Minnesota Statutes 2004, section 148.909, is amended to read:

148.909 [LICENSURE FOR VOLUNTEER PRACTICE.]

The board, at its discretion, may grant licensure for volunteer practice to an applicant who:

(1) ~~is-a-former-licensee-who~~ is completely retired from the practice of psychology;

(2) has no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction; and

(3) has held a license, certificate, or registration to practice psychology in any jurisdiction ~~for-at-least-15-years~~.

Sec. 7. Minnesota Statutes 2004, section 148.916, subdivision 2, is amended to read:

Subd. 2. [PSYCHOLOGICAL CONSULTATIONS.] Notwithstanding subdivision 1, a nonresident of the state of Minnesota, who is

not seeking licensure in this state, may serve as an expert witness, organizational consultant, presenter, or educator without obtaining guest licensure, provided the person is appropriately trained, educated, or has been issued a license, certificate, or registration by another jurisdiction.

Sec. 8. Minnesota Statutes 2004, section 148.925, subdivision 6, is amended to read:

Subd. 6. [SUPERVISEE DUTIES.] Individuals preparing for licensure as a licensed psychologist during their postdegree supervised employment may perform as part of their training any functions specified in section 148.89, subdivision 5, but only under qualified supervision.

Sec. 9. Minnesota Statutes 2004, section 148.941, subdivision 2, is amended to read:

Subd. 2. [GROUNDS FOR DISCIPLINARY ACTION; FORMS OF DISCIPLINARY ACTION.] (a) The board may impose disciplinary action as described in paragraph (b) against an applicant or licensee whom the board, by a preponderance of the evidence, determines:

(1) has violated a statute, rule, or order that the board issued or is empowered to enforce;

(2) has engaged in fraudulent, deceptive, or dishonest conduct, whether or not the conduct relates to the practice of psychology, that adversely affects the person's ability or fitness to practice psychology;

(3) has engaged in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;

(4) has been convicted of or has pled guilty or nolo contendere to a felony or other crime, an element of which is dishonesty or fraud, or has been shown to have engaged in acts or practices tending to show that the applicant or licensee is incompetent or has engaged in conduct reflecting adversely on the applicant's or licensee's ability or fitness to engage in

the practice of psychology;

(5) has employed fraud or deception in obtaining or renewing a license, in requesting approval of continuing education activities, or in passing an examination;

(6) has had a license, certificate, charter, registration, privilege to take an examination, or other similar authority denied, revoked, suspended, canceled, limited, reprimanded, or otherwise disciplined, or not renewed for cause in any jurisdiction; or has surrendered or voluntarily terminated a license or certificate during a board investigation of a complaint, as part of a disciplinary order, or while under a disciplinary order;

(7) has been subject to a corrective action or similar action in another jurisdiction or by another regulatory authority;

(8) has failed to meet any requirement for the issuance or renewal of the person's license. The burden of proof is on the applicant or licensee to demonstrate the qualifications or satisfy the requirements for a license under the Psychology Practice Act;

(9) has failed to cooperate with an investigation of the board as required under subdivision 4;

(10) has demonstrated an inability to practice psychology with reasonable skill and safety to clients due to any mental or physical illness or condition; or

(11) has engaged in fee splitting. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the licensee or under a licensee's administrative authority. This clause also does not apply to the charging of a general membership fee by a licensee or applicant to health care providers, as defined in section 144.335, for participation in a referral service, provided that the licensee or applicant discloses in advance to each referred client the financial

nature of the referral arrangement. Fee splitting includes, but is not limited to:

(i) paying, offering to pay, receiving, or agreeing to receive a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of clients;

(ii) dividing client fees with another individual or entity, unless the division is in proportion to the services provided and the responsibility assumed by each party;

(iii) referring an individual or entity to any health care provider, as defined in section 144.335, or for other professional or technical services in which the referring licensee or applicant has a significant financial interest unless the licensee has disclosed the financial interest in advance to the client; and

(iv) dispensing for profit or recommending any instrument, test, procedure, or device that for commercial purposes the licensee or applicant has developed or distributed, unless the licensee or applicant has disclosed any profit interest in advance to the client.

(b) If grounds for disciplinary action exist under paragraph (a), the board may take one or more of the following actions:

(1) refuse to grant or renew a license;

(2) revoke a license;

(3) suspend a license;

(4) impose limitations or conditions on a licensee's practice of psychology, including, but not limited to, limiting the scope of practice to designated competencies, imposing retraining or rehabilitation requirements, requiring the licensee to practice under supervision, or conditioning continued practice on the demonstration of knowledge or skill by appropriate examination or other review of skill and competence;

(5) censure or reprimand the licensee;

(6) refuse to permit an applicant to take the licensure examination or refuse to release an applicant's examination grade if the board finds that it is in the public interest; or

(7) impose a civil penalty not exceeding $7,500 for each separate violation. The amount of the penalty shall be fixed so as to deprive the applicant or licensee of any economic advantage gained by reason of the violation charged, to discourage repeated violations, or to recover the board's costs that occur in bringing about a disciplinary order. For purposes of this clause, costs are limited to legal, paralegal, and investigative charges billed to the board by the Attorney General's Office, witness costs, consultant and expert witness fees, and charges attendant to the use of an administrative law judge.

(c) In lieu of or in addition to paragraph (b), the board may require, as a condition of ~~continued~~ licensure, termination of suspension, reinstatement of license, examination, or release of examination grades, that the applicant or licensee:

(1) submit to a quality review, as specified by the board, of the applicant's or licensee's ability, skills, or quality of work;

(2) complete to the satisfaction of the board educational courses specified by the board; and

(3) reimburse to the board all costs incurred by the board that are the result of a provider failing, neglecting, or refusing to fully comply, or not complying in a timely manner, with any part of the remedy section of a stipulation and consent order or the corrective action section of an agreement for corrective action. For purposes of this clause, costs are limited to legal, paralegal, and investigative charges billed to the board by the Attorney General's Office, witness costs, consultant and expert witness fees, and charges attendant to the use of an administrative law judge.

(d) Service of the order is effective if the order is served on the applicant, licensee, or counsel of record personally or by mail to the most recent address provided to the board for the licensee, applicant, or counsel of record. The order shall state the reasons for the entry of the order.

Sec. 10. Minnesota Statutes 2004, section 148.96,

subdivision 3, is amended to read:

Subd. 3. [REQUIREMENTS FOR REPRESENTATIONS TO PUBLIC.] (a) Unless licensed under sections 148.88 to 148.98, except as provided in paragraphs (b) through (e), persons shall not represent themselves or permit themselves to be represented to the public by:

(1) using any title or description of services incorporating the words "psychology," "psychological," "psychological practitioner," or "psychologist"; or

(2) representing that the person has expert qualifications in an area of psychology.

(b) Psychologically trained individuals who are employed by an educational institution recognized by a regional accrediting organization, by a federal, state, county, or local government institution, ~~by agencies~~ agency, or ~~by~~ research ~~facilities~~ facility, may represent themselves by the title designated by that organization provided that the title does not indicate that the individual is credentialed by the board.

(c) A psychologically trained individual from an institution described in paragraph (b) may offer lecture services and is exempt from the provisions of this section.

(d) A person who is preparing for the practice of psychology under supervision in accordance with board statutes and rules may be designated as a "psychological intern," "psychological trainee," or by other terms clearly describing the person's training status.

(e) Former licensees who are completely retired from the practice of psychology may represent themselves using the descriptions in paragraph (a), clauses (1) and (2), but shall not represent themselves or allow themselves to be represented as current licensees of the board.

(f) Nothing in this section shall be construed to prohibit the practice of school psychology by a person licensed in accordance with chapters 122A and 129.

Section 11. [EFFECTIVE DATE.]

Sections 1 to 10 are effective the day following final

enactment.

ARTICLE 4

BOARD OF DENTAL PRACTICE

Section 1. Minnesota Statutes 2004, section 150A.01, subdivision 6a, is amended to read:

Subd. 6a. [FACULTY DENTIST.] "Faculty dentist" means a person who is licensed to practice dentistry as a faculty member of a school of dentistry, pursuant to section 150A.06, subdivision 1a.

Sec. 2. Minnesota Statutes 2004, section 150A.06, subdivision 1a, is amended to read:

Subd. 1a. [FACULTY DENTISTS.] (a) Faculty members of a school of dentistry must be licensed in order to practice dentistry as defined in section 150A.05. The board may issue to members of the faculty of a school of dentistry a license designated as either a "limited faculty license" or a "full faculty license" entitling the holder to practice dentistry within the terms described in paragraph (b) or (c). The dean of a school of dentistry and program directors of a Minnesota dental hygiene or dental assisting school accredited by the Commission on Dental Accreditation of the American Dental Association shall certify to the board those members of the school's faculty who practice dentistry but are not licensed to practice dentistry in Minnesota. A faculty member who practices dentistry as defined in section 150A.05, before beginning duties in a school of dentistry or a dental hygiene or dental assisting school, shall apply to the board for a limited or full faculty license. ~~The license expires the next July 1 and may, at the discretion of the board, be renewed on a yearly basis.~~ Pursuant to Minnesota Rules, chapter 3100, and at the discretion of the board, a limited faculty license must be renewed annually and a full faculty license must be renewed biennially. The faculty applicant shall pay a nonrefundable fee set by the board for issuing and renewing the faculty license. The faculty license is valid during the time the holder remains a member of the faculty of a school of dentistry or a dental hygiene or dental

assisting school and subjects the holder to this chapter.

(b) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation of the American Dental Association, a license designated as a limited faculty license entitling the holder to practice dentistry within the school and its affiliated teaching facilities, but only for the purposes of teaching or conducting research. The practice of dentistry at a school facility for purposes other than teaching or research is not allowed unless the dentist was a faculty member on August 1, 1993.

(c) The board may issue to dentist members of the faculty of a Minnesota school of dentistry, dental hygiene, or dental assisting accredited by the Commission on Dental Accreditation of the American Dental Association a license designated as a full faculty license entitling the holder to practice dentistry within the school and its affiliated teaching facilities and elsewhere if the holder of the license is employed 50 percent time or more by the school in the practice of teaching or research, and upon successful review by the board of the applicant's qualifications as described in subdivisions 1, 1c, and 4 and board rule. The board, at its discretion, may waive specific licensing prerequisites.

Sec. 3. [150A.091] [FEES.]

Subdivision 1. [FEE REFUNDS.] No fee may be refunded for any reason.

Subd. 2. [APPLICATION FEES.] Each applicant for licensure or registration shall submit with a license or registration application a nonrefundable fee in the following amounts in order to administratively process an application:

(1) dentist, $140;

(2) limited faculty dentist, $140;

(3) resident dentist, $55;

(4) dental hygienist, $55;

(5) registered dental assistant, $35; and

(6) dental assistant with a limited registration, $15.

Subd. 3. [INITIAL LICENSE OR REGISTRATION FEES.] Along with the application fee, each of the following licensees or registrants shall submit a separate prorated initial license or registration fee. The prorated initial fee shall be established by the board based on the number of months of the licensee's or registrant's initial term as described in Minnesota Rules, part 3100.1700, subpart 1a, not to exceed the following monthly fee amounts:

(1) dentist, $14 times the number of months of the initial term;

(2) dental hygienist, $5 times the number of months of the initial term;

(3) registered dental assistant, $3 times the number of months of initial term; and

(4) dental assistant with a limited registration, $1 times the number of months of the initial term.

Subd. 4. [ANNUAL LICENSE FEES.] Each limited faculty or resident dentist shall submit with an annual license renewal application a fee established by the board not to exceed the following amounts:

(1) limited faculty dentist, $168; and

(2) resident dentist, $59.

Subd. 5. [BIENNIAL LICENSE OR REGISTRATION FEES.] Each of the following licensees or registrants shall submit with a biennial license or registration renewal application a fee as established by the board, not to exceed the following amounts:

(1) dentist, $336;

(2) dental hygienist, $118;

(3) registered dental assistant, $80; and

(4) dental assistant with a limited registration, $24.

Subd. 6. [ANNUAL LICENSE LATE FEE.] Applications for renewal of any license received after the time specified in Minnesota Rules, part 3100.1750, must be assessed a late fee equal to 50 percent of the annual renewal fee.

Subd. 7. [BIENNIAL LICENSE OR REGISTRATION LATE FEE.] Applications for renewal of any license or registration

received after the time specified in Minnesota Rules, part 3100.1700, must be assessed a late fee equal to 25 percent of the biennial renewal fee.

Subd. 8. [DUPLICATE LICENSE OR REGISTRATION FEE.] Each licensee or registrant shall submit, with a request for issuance of a duplicate of the original license or registration, or of an annual or biennial renewal of it, a fee in the following amounts:

(1) original dentist or dental hygiene license, $35; and

(2) initial and renewal registration certificates and license renewal certificates, $10.

Subd. 9. [LICENSURE AND REGISTRATION BY CREDENTIALS.] Each applicant for licensure as a dentist or dental hygienist or for registration as a registered dental assistant by credentials pursuant to section 150A.06, subdivisions 4 and 8, and Minnesota Rules, part 3100.1400, shall submit with the license or registration application a fee in the following amounts:

(1) dentist, $725;

(2) dental hygienist, $175; and

(3) registered dental assistant, $35.

Subd. 10. [REINSTATEMENT FEE.] No dentist, dental hygienist, or registered dental assistant whose license or registration has been suspended or revoked may have the license or registration reinstated or a new license or registration issued until a fee has been submitted to the board in the following amounts:

(1) dentist, $140;

(2) dental hygienist, $55; and

(3) registered dental assistant, $35.

Subd. 11. [CERTIFICATE APPLICATION FEE FOR ANESTHESIA/SEDATION.] Each dentist shall submit with a general anesthesia or conscious sedation application a fee as established by the board not to exceed the following amounts:

(1) for both a general anesthesia and conscious sedation application, $50;

(2) for a general anesthesia application only, $50; and

(3) for a conscious sedation application only, $50.

Subd. 12. [DUPLICATE CERTIFICATE FEE FOR ANESTHESIA/SEDATION.] Each dentist shall submit with a request for issuance of a duplicate of the original general anesthesia or conscious sedation certificate a fee in the amount of $10.

Subd. 13. [ON-SITE INSPECTION FEE.] An on-site inspection fee must be paid to the individual, organization, or agency conducting the inspection and be limited to a maximum fee as determined by the board. Travel, lodging, and other expenses are not part of the on-site inspection fee.

Subd. 14. [AFFIDAVIT OF LICENSURE.] Each licensee or registrant shall submit with a request for an affidavit of licensure a fee in the amount of $10.

Subd. 15. [VERIFICATION OF LICENSURE.] Each institution or corporation shall submit with a request for verification of a license or registration a fee in the amount of $5 for each license or registration to be verified.

Sec. 4. Minnesota Statutes 2004, section 150A.10, subdivision 1a, is amended to read:

Subd. 1a. [LIMITED AUTHORIZATION FOR DENTAL HYGIENISTS.] (a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years;

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist;

(3) has documented participation in courses in infection control and medical emergencies within each continuing education cycle; and

(4) maintains current certification in advanced or basic

cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to:

(1) oral health promotion and disease prevention education;

(2) removal of deposits and stains from the surfaces of the teeth;

(3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(4) polishing and smoothing restorations;

(5) removal of marginal overhangs;

(6) performance of preliminary charting;

(7) taking of radiographs; and

(8) performance of scaling and root planing.

The dental hygienist shall not perform injections of anesthetic agents or the administration of nitrous oxide unless under either the indirect or general supervision of a licensed dentist. Collaborating dental hygienists may work with unregistered and registered dental assistants who may only perform duties for which registration is not required. The performance of dental hygiene services in a health care facility, program, or nonprofit organization as authorized under this subdivision is limited to patients, students, and residents of the facility, program, or organization.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise authorized by the board. The board shall develop parameters and a process for obtaining authorization to collaborate with more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene

services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(3) copies of consent to treatment form provided to the patient by the dental hygienist;

(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and

(5) a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist. This procedure must specify where these records are to be located. The collaborative agreement must be signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization; must be reviewed annually by the collaborating dentist and dental hygienist; and must be made available to the board upon request.

(d) Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. If the dental hygienist makes any referrals to the patient for further dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.

(e) For the purposes of this subdivision, a "health care facility, program, or nonprofit organization" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health

care public program recipients.

(f) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

ARTICLE 5

BOARD OF BEHAVIORAL THERAPY AND HEALTH

(LICENSED PROFESSIONAL COUNSELORS AND ALCOHOL AND DRUG COUNSELORS)

Section 1. Minnesota Statutes 2004, section 148B.53, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) To be licensed as a licensed professional counselor (LPC), an applicant must provide evidence satisfactory to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in paragraph (b), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than 700 hours that is counseling in nature;

(4) has submitted to the board a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board; and

(5) has demonstrated competence in professional counseling by passing the National Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc. (NBCC) ~~including obtaining a passing score on the examination accepted~~

~~by-the-board-based-on-the-determinations-made-by-the-NBCC~~ or an equivalent national examination as determined by the board, and ethical, oral, and situational examinations if prescribed by the board.

(b) The degree described in paragraph (a), clause (3), must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must ~~meet-standards established-by-the-CACREP,-including~~ include course work in each of the following subject areas:

(1) the helping relationship, including counseling theory and practice;

(2) human growth and development;

(3) lifestyle and career development;

(4) group dynamics, processes, counseling, and consulting;

(5) assessment and appraisal;

(6) social and cultural foundations, including multicultural issues;

(7) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;

(8) family counseling and therapy;

(9) research and evaluation; and

(10) professional counseling orientation and ethics.

(c) To be licensed as a professional counselor, a psychological practitioner licensed under section 148.908 need only show evidence of licensure under that section and is not required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).

(d) To be licensed as a professional counselor, a Minnesota licensed psychologist need only show evidence of licensure from the Minnesota Board of Psychology and is not required to comply with paragraph (a) or (b).

Sec. 2. Minnesota Statutes 2004, section 148B.53, subdivision 3, is amended to read:

Subd. 3. [FEE.] ~~Each applicant shall pay a~~ Nonrefundable ~~fee~~ fees are as follows:

(1) initial license application fee for licensed professional counseling (LPC) - $250;

(2) annual active license renewal fee for LPC - $200 or equivalent;

(3) annual inactive license renewal fee for LPC - $100;

(4) license renewal late fee - $100 per month or portion thereof;

(5) copy of board order or stipulation - $10;

(6) certificate of good standing or license verification - $10;

(7) duplicate certificate fee - $10;

(8) professional firm renewal fee - $25;

(9) initial registration fee - $50; and

(10) annual registration renewal fee - $25.

Sec. 3. [148B.531] [POSTDEGREE COMPLETION OF DEGREE REQUIREMENTS FOR LICENSURE.]

An individual whose degree upon which licensure is to be based included less than 48 semester hours or 72 quarter hours, who did not complete 700 hours of supervised professional practice as part of the degree program, or who did not complete course work in all of the content areas required by section 148B.53, subdivision 1, paragraph (b), may complete these requirements postdegree in order to obtain licensure, if:

(1) all course work and field experiences are completed through an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA) or through a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP);

(2) all course work and field experiences are taken and passed for credit; and

(3) no more than 20 semester credits or 30 quarter credits

are completed postdegree for purposes of licensure unless the credits are earned as part of an organized sequence of study.

Sec. 4. Minnesota Statutes 2004, section 148B.54, subdivision 2, is amended to read:

Subd. 2. [CONTINUING EDUCATION.] At the completion of the first ~~two~~ four years of licensure, a licensee must provide evidence satisfactory to the board of completion of 12 additional postgraduate semester credit hours or its equivalent in counseling as determined by the board, except that no licensee shall be required to show evidence of greater than 60 semester hours or its equivalent. Thereafter, at the time of renewal, each licensee shall provide evidence satisfactory to the board that the licensee has completed during each two-year period at least the equivalent of 40 clock hours of professional postdegree continuing education in programs approved by the board and continues to be qualified to practice under sections 148B.50 to 148B.593.

Sec. 5. [148B.555] [EXPERIENCED COUNSELOR TRANSITION.]

(a) An applicant for licensure who, prior to December 31, 2003, completed a master's or doctoral degree program in counseling or a related field, as determined by the board, and whose degree was from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA), need not comply with the requirements of section 148B.53, subdivision 1, paragraph (a), clause (3), or (b), so long as the applicant can document five years of full-time postdegree work experience within the practice of professional counseling as defined under section 148B.50, subdivisions 4 and 5.

(b) This section expires July 1, 2007.

Sec. 6. [148B.561] [RETALIATORY PROVISIONS.]

If by the laws of any state or the rulings or decisions of the appropriate officers or boards thereof, any burden,

obligation, requirement, disqualification, or disability is put upon licensed professional counselors licensed and in good standing in this state, affecting the right of these licensed professional counselors to be registered or licensed in that state, then the same or like burden, obligation, requirement, disqualification, or disability may be put upon the licensure in this state of licensed professional counselors registered in that state.

Sec. 7. Minnesota Statutes 2004, section 148B.59, is amended to read:

148B.59 [GROUNDS FOR DISCIPLINARY ACTION; FORMS OF DISCIPLINARY ACTION; RESTORATION OF LICENSE.]

(a) The board may impose disciplinary action as described in paragraph (b) against an applicant or licensee whom the board, by a preponderance of the evidence, determines:

(1) has violated a statute, rule, or order that the board issued or is empowered to enforce;

(2) has engaged in fraudulent, deceptive, or dishonest conduct, whether or not the conduct relates to the practice of licensed professional counseling, that adversely affects the person's ability or fitness to practice professional counseling;

(3) has engaged in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;

(4) has been convicted of or has pled guilty or nolo contendere to a felony or other crime, an element of which is dishonesty or fraud, or has been shown to have engaged in acts or practices tending to show that the applicant or licensee is incompetent or has engaged in conduct reflecting adversely on the applicant's or licensee's ability or fitness to engage in the practice of professional counseling;

(5) has employed fraud or deception in obtaining or renewing a license, or in passing an examination;

(6) has had any counseling license, certificate,

registration, privilege to take an examination, or other similar authority denied, revoked, suspended, canceled, limited, or not renewed for cause in any jurisdiction or has surrendered or voluntarily terminated a license or certificate during a board investigation of a complaint, as part of a disciplinary order, or while under a disciplinary order;

(7) has failed to meet any requirement for the issuance or renewal of the person's license. The burden of proof is on the applicant or licensee to demonstrate the qualifications or satisfy the requirements for a license under the Licensed Professional Counseling Act;

(8) has failed to cooperate with an investigation of the board;

(9) has demonstrated an inability to practice professional counseling with reasonable skill and safety to clients due to any mental or physical illness or condition;

(10) has engaged in fee splitting. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the licensee or under a licensee's administrative authority. Fee splitting includes, but is not limited to:

(i) dividing fees with another person or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional; ~~and~~

(ii) referring a client to any health care provider as defined in section 144.335 in which the referring licensee has a significant financial interest, unless the licensee has disclosed in advance to the client the licensee's own financial interest; ~~or~~ and

(iii) paying, offering to pay, receiving, or agreeing to receive a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of clients;

(11) has engaged in conduct with a ~~patient~~ client that is

sexual or may reasonably be interpreted by the ~~patient~~ client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a ~~patient~~ client;

(12) has been subject to a corrective action or similar action in another jurisdiction or by another regulatory authority; or

(13) has been adjudicated as mentally incompetent, mentally ill, or mentally retarded or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality by a court of competent jurisdiction within this state or an equivalent adjudication from another state. Adjudication automatically suspends a license for the duration thereof unless the board orders otherwise.

(b) If grounds for disciplinary action exist under paragraph (a), the board may take one or more of the following actions:

(1) refuse to grant or renew a license;

(2) revoke a license;

(3) suspend a license;

(4) impose limitations or conditions on a licensee's practice of professional counseling, including, but not limited to, limiting the scope of practice to designated competencies, imposing retraining or rehabilitation requirements, requiring the licensee to practice under supervision, or conditioning continued practice on the demonstration of knowledge or skill by appropriate examination or other review of skill and competence;

(5) censure or reprimand the licensee;

(6) refuse to permit an applicant to take the licensure examination or refuse to release an applicant's examination grade if the board finds that it is in the public interest; or

(7) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the applicant or licensee of any economic advantage gained by reason of the violation charged, to discourage similar violations or to reimburse the board for the

cost of the investigation and proceeding, including, but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(c) In lieu of or in addition to paragraph (b), the board may require, as a condition of continued licensure, termination of suspension, reinstatement of license, examination, or release of examination grades, that the applicant or licensee:

(1) submit to a quality review, as specified by the board, of the applicant's or licensee's ability, skills, or quality of work; and

(2) complete to the satisfaction of the board educational courses specified by the board.

The board may also refer a licensee, if appropriate, to the health professionals services program described in sections 214.31 to 214.37.

(d) Service of the order is effective if the order is served on the applicant, licensee, or counsel of record personally or by mail to the most recent address provided to the board for the licensee, applicant, or counsel of record. The order shall state the reasons for the entry of the order.

Sec. 8. [148B.5901] [TEMPORARY SUSPENSION OF LICENSE.]

(a) In addition to any other remedy provided by law, the board may issue an order to temporarily suspend the credentials of a licensee after conducting a preliminary inquiry to determine if the board reasonably believes that the licensee has violated a statute or rule that the board is empowered to enforce and whether continued practice by the licensee would create an imminent risk of harm to others.

(b) The order may prohibit the licensee from engaging in the practice of licensed professional counseling in whole or in part and may condition the end of a suspension on the licensee's compliance with a statute, rule, or order that the board has

issued or is empowered to enforce.

(c) The order shall give notice of the right to a hearing according to this subdivision and shall state the reasons for the entry of the order.

(d) Service of the order is effective when the order is served on the licensee personally or by certified mail, which is complete upon receipt, refusal, or return for nondelivery to the most recent address provided to the board for the licensee.

(e) At the time the board issues a temporary suspension order, the board shall schedule a hearing to be held before its own members. The hearing shall begin no later than 60 days after issuance of the temporary suspension order or within 15 working days of the date of the board's receipt of a request for hearing by a licensee, on the sole issue of whether there is a reasonable basis to continue, modify, or lift the temporary suspension. The hearing is not subject to chapter 14. Evidence presented by the board or the licensee shall be in affidavit form only. The licensee or counsel of record may appear for oral argument.

(f) Within five working days of the hearing, the board shall issue its order and, if the suspension is continued, schedule a contested case hearing within 30 days of the issuance of the order. Notwithstanding chapter 14, the administrative law judge shall issue a report within 30 days after closing the contested case hearing record. The board shall issue a final order within 30 days of receipt of the administrative law judge's report.

Sec. 9. [148B.5905] [MENTAL, PHYSICAL, OR CHEMICAL DEPENDENCY EXAMINATION OR EVALUATION; ACCESS TO MEDICAL DATA.]

(a) If the board has probable cause to believe section 148B.59, paragraph (a), clause (9), applies to a licensee or applicant, the board may direct the person to submit to a mental, physical, or chemical dependency examination or evaluation. For the purpose of this section, every licensee and applicant is deemed to have consented to submit to a mental, physical, or chemical dependency examination or evaluation when

directed in writing by the board and to have waived all objections to the admissibility of the examining professionals' testimony or examination reports on the grounds that the testimony or examination reports constitute a privileged communication. Failure of a licensee or applicant to submit to an examination when directed by the board constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A licensee or applicant affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of licensed professional counseling with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a licensee or applicant in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that section 148B.59, paragraph (a), clause (9), applies to the licensee or applicant. The medical data may be requested from a provider, as defined in section 144.335, subdivision 1, paragraph (b); an insurance company; or a government agency, including the Department of Human Services. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to

13.87.

Sec. 10. [148B.5925] [ASSESSMENT TOOL SECURITY.]

Notwithstanding section 144.335, subdivision 2, paragraphs (a) and (b), a provider shall not be required to provide copies of assessment tools, assessment tool materials, or scoring keys to any individual who has completed an assessment tool or to an individual not qualified to administer, score, and interpret the assessment tool, if the provider reasonably determines that access would compromise the objectivity, fairness, or integrity of the testing process for the individual or others. If the provider makes this determination, the provider shall, at the discretion of the individual who has completed the assessment tool, release the information either to another provider who is qualified to administer, score, and interpret the assessment tool or furnish a summary of the assessment tool results to the individual or to a third party designated by the individual.

Sec. 11. Minnesota Statutes 2004, section 148C.03, subdivision 1, is amended to read:

Subdivision 1. [GENERAL.] The commissioner shall~~,-after consultation-with-the-advisory-council-or-a-committee established-by-rule~~:

(a) adopt and enforce rules for licensure of alcohol and drug counselors, including establishing standards and methods of determining whether applicants and licensees are qualified under section 148C.04. The rules must provide for examinations and establish standards for the regulation of professional conduct. The rules must be designed to protect the public;

~~(b) develop-and,-at-least-twice-a-year,-administer-an examination-to-assess-applicants'-knowledge-and-skills.--The commissioner-may-contract-for-the-administration-of-an examination-with-an-entity-designated-by-the-commissioner.--The examinations-must-be-psychometrically-valid-and-reliable,-must be-written-and-oral,-with-the-oral-examination-based-on-a written-case-presentation,-must-minimize-cultural-bias,-and-must be-balanced-in-various-theories-relative-to-the-practice-of alcohol-and-drug-counseling,~

~~(c)~~ issue licenses to individuals qualified under sections 148C.01 to 148C.11;

~~(d)~~ (c) issue copies of the rules for licensure to all applicants;

~~(e)~~ (d) adopt rules to establish and implement procedures, including a standard disciplinary process and rules of professional conduct;

~~(f)~~ (e) carry out disciplinary actions against licensees;

~~(g)~~ (f) establish~~, with the advice and recommendations of the advisory council,~~ written internal operating procedures for receiving and investigating complaints and for taking disciplinary actions as appropriate;

~~(h)~~ (g) educate the public about the existence and content of the rules for alcohol and drug counselor licensing to enable consumers to file complaints against licensees who may have violated the rules;

~~(i)~~ (h) evaluate the rules in order to refine and improve the methods used to enforce the commissioner's standards; and

~~(j)~~ (i) collect license fees for alcohol and drug counselors.

Sec. 12. Minnesota Statutes 2004, section 148C.04, subdivision 3, is amended to read:

Subd. 3. [REQUIREMENTS FOR LICENSURE BEFORE JULY 1, 2008.] An applicant for a license must furnish evidence satisfactory to the commissioner that the applicant has met all the requirements in clauses (1) to (3). The applicant must have:

(1) received an associate degree, or an equivalent number of credit hours, and a certificate in alcohol and drug counseling, including 18 semester credits or 270 clock hours of academic course work in accordance with subdivision 5a, paragraph (a), from an accredited school or educational program and 880 clock hours of supervised alcohol and drug counseling practicum;

(2) completed one of the following:

(i) a written case presentation and satisfactorily passed an oral examination ~~established by the commissioner~~ that

demonstrates competence in the core functions as determined by the board; or

(ii) satisfactorily completed 2,000 hours of supervised postdegree equivalent professional practice in accordance with section 148C.044; and

(3) satisfactorily passed a written ~~examination as established by the commissioner~~ examinations for licensure as determined by the board.

Sec. 13. Minnesota Statutes 2004, section 148C.04, subdivision 4, is amended to read:

Subd. 4. [REQUIREMENTS FOR LICENSURE AFTER JULY 1, 2008.] An applicant for a license must submit evidence to the commissioner that the applicant has met one of the following requirements:

(1) the applicant must have:

(i) received a bachelor's degree from an accredited school or educational program, including 18 semester credits or 270 clock hours of academic course work in accordance with subdivision 5a, paragraph (a), from an accredited school or educational program and 880 clock hours of supervised alcohol and drug counseling practicum;

(ii) completed a written case presentation and satisfactorily passed an oral examination established by the commissioner that demonstrates competence in the core functions; or submitted to the board a plan for supervision during the first 2,000 hours of professional practice, or submitted proof of supervised professional practice that is acceptable to the commissioner; and

(iii) satisfactorily passed a written examination as established by the commissioner; or

(2) the applicant must meet the requirements of section 148C.07.

Sec. 14. Minnesota Statutes 2004, section 148C.04, subdivision 6, is amended to read:

Subd. 6. [TEMPORARY PERMIT REQUIREMENTS.] (a) The commissioner shall issue a temporary permit to practice alcohol

and drug counseling prior to being licensed under this chapter if the person:

(1) either:

(i) submits verification of a current and unrestricted credential for the practice of alcohol and drug counseling from a national certification body or a certification or licensing body from another state, United States territory, or federally recognized tribal authority;

(ii) submits verification of the completion of at least 64 semester credits, including 270 clock hours or 18 semester credits of formal classroom education in alcohol and drug counseling and at least 880 clock hours of alcohol and drug counseling practicum from an accredited school or educational program;

(iii) applies to renew a lapsed license according to the requirements of section 148C.055, subdivision 3, clauses (1) and (2), or section 148C.055, subdivision 4, clauses (1) and (2); or

(iv) meets the requirements of section 148C.11, subdivision 1, paragraph (c), or 6, clauses (1), (2), and (5);

(2) applies, in writing, on an application form provided by the commissioner, which includes the nonrefundable temporary permit fee as specified in section 148C.12 and an affirmation by the person's supervisor, as defined in paragraph (c), clause (1), which is signed and dated by the person and the person's supervisor; and

(3) has not been disqualified to practice temporarily on the basis of a background investigation under section 148C.09, subdivision 1a.

(b) The commissioner must notify the person in writing within 90 days from the date the completed application and all required information is received by the commissioner whether the person is qualified to practice under this subdivision.

(c) A person practicing under this subdivision:

(1) may practice under tribal jurisdiction or under the direct supervision of a person who is licensed under this chapter;

(2) is subject to the Rules of Professional Conduct set by rule; and

(3) is not subject to the continuing education requirements of section 148C.075.

(d) A person practicing under this subdivision must use the title or description stating or implying that the person is a trainee engaged in the practice of alcohol and drug counseling.

(e) A person practicing under this subdivision must annually submit a renewal application on forms provided by the commissioner with the renewal fee required in section 148C.12, subdivision 3, and the commissioner may renew the temporary permit if the trainee meets the requirements of this subdivision. A trainee may renew a practice permit no more than five times.

(f) A temporary permit expires if not renewed, upon a change of employment of the trainee or upon a change in supervision, or upon the granting or denial by the commissioner of a license.

Sec. 15. [148C.044] [SUPERVISED POSTDEGREE PROFESSIONAL PRACTICE.]

Subdivision 1. [SUPERVISION.] For the purpose of this section, "supervision" means documented interactive consultation, which, subject to the limitations in subdivision 4, paragraph (a), clause (2), may be conducted in person, by telephone, or by audio or audiovisual electronic device, with a supervisor as defined in subdivision 2. The supervision must be adequate to ensure the quality and competence of the activities supervised. Supervisory consultation must include discussions on the nature and content of the practice of the supervisee, including, but not limited to, a review of a representative sample of counseling services in the supervisee's practice.

Subd. 2. [POSTDEGREE PROFESSIONAL PRACTICE.] "Postdegree professional practice" means required postdegree paid or volunteer work experience and training that involves the professional oversight by a supervisor approved by the board and that satisfies the supervision requirements in subdivision 4.

Subd. 3. [SUPERVISOR REQUIREMENTS.] For purposes of this section, a supervisor shall:

(1) be a licensed alcohol and drug counselor or other qualified professional as determined by the board;

(2) have four years of experience in providing alcohol and drug counseling;

(3) have received a minimum of 12 hours of training in clinical and ethical supervision, which may include graduate course work, continuing education courses, workshops, or a combination thereof; and

(4) supervise no more than three persons in postdegree professional practice.

Subd. 4. [SUPERVISED PRACTICE REQUIREMENTS FOR LICENSURE.] (a) The content of supervision must include:

(1) knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, including the core functions as described in section 148C.01, subdivision 9;

(2) the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics; and

(3) the supervisee's permissible scope of practice, as defined by section 148C.01, subdivision 10.

(b) The supervision must be obtained at the rate of one hour of supervision per 40 hours of professional practice, for a total of 50 hours of supervision. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(c) The supervision must be completed in no fewer than 12

consecutive months and no more than 36 consecutive months.

(d) The applicant shall include with an application for licensure verification of completion of the 2,000 hours of supervised professional practice. Verification must be on a form specified by the board. The supervisor shall verify that the supervisee has completed the required hours of supervision in accordance with this section. The supervised practice required under this section is unacceptable if the supervisor attests that the supervisee's performance, competence, or adherence to the standards of practice and ethical conduct has been unsatisfactory.

Sec. 16. Minnesota Statutes 2004, section 148C.091, subdivision 1, is amended to read:

Subdivision 1. [FORMS OF DISCIPLINARY ACTION.] When the commissioner finds that an applicant or a licensed alcohol and drug counselor has violated a provision or provisions of sections 148C.01 to 148C.11, or rules promulgated under this chapter, the commissioner may take one or more of the following actions:

(1) refuse to grant a license;

(2) revoke the license;

(3) suspend the license;

(4) impose limitations or conditions;

(5) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the counselor of any economic advantage gained by reason of the violation charged or to reimburse the commissioner for all costs of the investigation and proceeding; including, but not limited to, the amount paid by the commissioner for services from the Office of Administrative Hearings, attorney fees, court reports, witnesses, reproduction of records, ~~advisory council members' per diem compensation,~~ staff time, and expense incurred by ~~advisory council members and~~ staff of the department;

(6) order the counselor to provide uncompensated professional service under supervision at a designated public

hospital, clinic, or other health care institution;

(7) censure or reprimand the counselor; or

(8) any other action justified by the case.

Sec. 17. Minnesota Statutes 2004, section 148C.10, subdivision 2, is amended to read:

Subd. 2. [USE OF TITLES.] No person shall present themselves or any other individual to the public by any title incorporating the words "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are licensed or otherwise qualified to practice alcohol and drug counseling unless that individual holds a valid license. Persons issued a temporary permit must use titles consistent with section 148C.04, subdivision 6, paragraph ~~(c)~~ (d).

Sec. 18. Minnesota Statutes 2004, section 148C.11, subdivision 1, is amended to read:

Subdivision 1. [OTHER PROFESSIONALS.] (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to~~,~~: licensed physicians~~,~~; registered nurses~~,~~; licensed practical nurses~~,~~; licensed psychological practitioners~~,~~; members of the clergy~~,~~; American Indian medicine men and women~~,~~; licensed attorneys~~,~~; probation officers~~,~~; licensed marriage and family therapists~~,~~; licensed social workers~~,~~; social workers employed by city, county, or state agencies; licensed professional counselors~~,~~; licensed school counselors~~,~~; registered occupational therapists or occupational therapy assistants~~,~~; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and until July 1, 2005, individuals providing integrated dual-diagnosis treatment in adult mental health rehabilitative programs certified by the Department of Human Services under section 256B.0622 or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of

Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt under this ~~section~~ subdivision but who elects to obtain a license under this chapter is subject to this chapter to the same extent as other licensees. The commissioner shall issue a license without examination to an applicant who is licensed or registered in a profession identified in paragraph (a) if the applicant:

(1) shows evidence of current licensure or registration; and

(2) has submitted to the commissioner a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the commissioner.

(d) ~~These persons~~ Any person who is exempt from licensure under this section must not~~, however,~~ use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are engaged in the practice of alcohol and drug counseling, or that they are licensed to engage in the practice of alcohol and drug counseling unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the commissioner's jurisdiction solely by the use of one of the above titles.

Sec. 19. Minnesota Statutes 2004, section 148C.11, subdivision 4, is amended to read:

Subd. 4. [HOSPITAL ALCOHOL AND DRUG COUNSELORS.] Effective January 1, ~~2006~~ 2007, hospitals employing alcohol and drug counselors shall be required to employ licensed alcohol and drug counselors. An alcohol or drug counselor employed by a hospital must be licensed as an alcohol and drug counselor in accordance with this chapter.

Sec. 20. Minnesota Statutes 2004, section 148C.11, subdivision 5, is amended to read:

Subd. 5. [CITY, COUNTY, AND STATE AGENCY ALCOHOL AND DRUG

COUNSELORS.] Effective January 1, ~~2006~~ 2007, city, county, and state agencies employing alcohol and drug counselors shall be required to employ licensed alcohol and drug counselors. An alcohol and drug counselor employed by a city, county, or state agency must be licensed as an alcohol and drug counselor in accordance with this chapter.

Sec. 21. Minnesota Statutes 2004, section 148C.11, subdivision 6, is amended to read:

Subd. 6. [TRANSITION PERIOD FOR HOSPITAL AND CITY, COUNTY, AND STATE AGENCY ALCOHOL AND DRUG COUNSELORS.] For the period between July 1, 2003, and January 1, ~~2006~~ 2007, the commissioner shall grant a license to an individual who is employed as an alcohol and drug counselor at a Minnesota school district or hospital, or a city, county, or state agency in Minnesota, if the individual meets the requirements in section 148C.0351 and:

(1) was employed as an alcohol and drug counselor at a school district, a hospital, or a city, county, or state agency before August 1, 2002; ~~(2)~~ has 8,000 hours of alcohol and drug counselor work experience; ~~(3)~~ has completed a written case presentation and satisfactorily passed an oral examination established by the commissioner; ~~(4)~~ and has satisfactorily passed a written examination as established by the commissioner; ~~and (5) meets the requirements in section 148C.0351~~ or

(2) is credentialed as a board certified counselor (BCC) or board certified counselor reciprocal (BCCR) by the Minnesota Certification Board; or

(3) has 14,000 hours of supervised alcohol and drug counselor work experience as documented by the employer.

Sec. 22. Minnesota Statutes 2004, section 148C.12, subdivision 3, is amended to read:

Subd. 3. [TEMPORARY PERMIT FEE.] The initial fee for applicants under section 148C.04, subdivision 6, paragraph (a), is $100. The fee for annual renewal of a temporary permit is ~~$100~~ $150, but when the first expiration date occurs in less or more than one year, the fee must be prorated.

Sec. 23. Minnesota Statutes 2004, section 214.01,

subdivision 2, is amended to read:

Subd. 2. [HEALTH-RELATED LICENSING BOARD.] "Health-related licensing board" means the Board of Examiners of Nursing Home Administrators established pursuant to section 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice established pursuant to section 146A.02, the Board of Medical Practice created pursuant to section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry established pursuant to section 148.52, the Board of Physical Therapy established pursuant to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board of Social Work pursuant to section 148B.19, the Board of Marriage and Family Therapy pursuant to section 148B.30, the Office of Mental Health Practice established pursuant to section 148B.61, the Board of Behavioral Health and Therapy established by section 148B.51, ~~the Alcohol and Drug Counselors Licensing Advisory Council established pursuant to section 148C.02,~~ the Board of Dietetics and Nutrition Practice established under section 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established pursuant to section 153.02, and the Board of Veterinary Medicine, established pursuant to section 156.01.

Sec. 24. Minnesota Statutes 2004, section 214.103, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION.] For purposes of this section, "board" means "health-related licensing board" and does not include ~~the Alcohol and Drug Counselors Licensing Advisory Council established pursuant to section 148C.02, or~~ the non-health-related licensing boards. Nothing in this section supersedes section 214.10, subdivisions 2a, 3, 8, and 9, as they apply to the health-related licensing boards.

Sec. 25. [AUTHORIZATION FOR EXPEDITED RULEMAKING AUTHORITY.]

The Board of Behavioral Health and Therapy may use the

expedited rulemaking process under Minnesota Statutes, section 14.389, for adopting and amending rules to conform with sections 1 to 10.

Sec. 26. [REPEALER.]

(a) Minnesota Statutes 2004, sections 148C.02 and 148C.12, subdivision 4, are repealed.

(b) Minnesota Rules, parts 4747.0030, subparts 11 and 16; 4747.1200; and 4747.1300, are repealed.

Sec. 27. [EFFECTIVE DATE.]

This article is effective July 1, 2005.

ARTICLE 6

BOARD OF MEDICAL PRACTICE

(PHYSICIAN ASSISTANTS AND RESPIRATORY CARE PRACTITIONERS)

Section 1. Minnesota Statutes 2004, section 147A.18, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION.] (a) A supervising physician may delegate to a physician assistant who is registered with the board, certified by the National Commission on Certification of Physician Assistants or successor agency approved by the board, and who is under the supervising physician's supervision, the authority to prescribe, dispense, and administer legend drugs, medical devices, and controlled substances subject to the requirements in this section. The authority to dispense includes, but is not limited to, the authority to request, receive, and dispense sample drugs. This authority to dispense extends only to those drugs described in the written agreement developed under paragraph (b).

(b) The agreement between the physician assistant and supervising physician and any alternate supervising physicians must include a statement by the supervising physician regarding delegation or nondelegation of the functions of prescribing, dispensing, and administering of legend drugs and medical devices to the physician assistant. The statement must include a protocol indicating categories of drugs for which the supervising physician delegates prescriptive and dispensing authority. The delegation must be appropriate to the physician

assistant's practice and within the scope of the physician assistant's training. Physician assistants who have been delegated the authority to prescribe, dispense, and administer legend drugs and medical devices shall provide evidence of current certification by the National Commission on Certification of Physician Assistants or its successor agency when registering or reregistering as physician assistants. Physician assistants who have been delegated the authority to prescribe controlled substances must present evidence of the certification and hold a valid DEA certificate. Supervising physicians shall retrospectively review the prescribing, dispensing, and administering of legend and controlled drugs and medical devices by physician assistants, when this authority has been delegated to the physician assistant as part of the delegation agreement between the physician and the physician assistant. This review must take place ~~at least weekly~~ as outlined in the internal protocol. The process and schedule for the review must be outlined in the delegation agreement.

(c) The board may establish by rule:

(1) a system of identifying physician assistants eligible to prescribe, administer, and dispense legend drugs and medical devices;

(2) a system of identifying physician assistants eligible to prescribe, administer, and dispense controlled substances;

(3) a method of determining the categories of legend and controlled drugs and medical devices that each physician assistant is allowed to prescribe, administer, and dispense; and

(4) a system of transmitting to pharmacies a listing of physician assistants eligible to prescribe legend and controlled drugs and medical devices.

Sec. 2. Minnesota Statutes 2004, section 147A.18, subdivision 3, is amended to read:

Subd. 3. [OTHER REQUIREMENTS AND RESTRICTIONS.] (a) The supervising physician and the physician assistant must complete, sign, and date an internal protocol which lists each category of drug or medical device, or controlled substance the physician

assistant may prescribe, dispense, and administer. The supervising physician and physician assistant shall submit the internal protocol to the board upon request. The supervising physician may amend the internal protocol as necessary, within the limits of the completed delegation form in subdivision 5. The supervising physician and physician assistant must sign and date any amendments to the internal protocol. Any amendments resulting in a change to an addition or deletion to categories delegated in the delegation form in subdivision 5 must be submitted to the board according to this chapter, along with the fee required.

(b) The supervising physician and physician assistant shall review delegation of prescribing, dispensing, and administering authority on an annual basis at the time of reregistration. The internal protocol must be signed and dated by the supervising physician and physician assistant after review. Any amendments to the internal protocol resulting in changes to the delegation form in subdivision 5 must be submitted to the board according to this chapter, along with the fee required.

(c) Each prescription initiated by a physician assistant shall indicate the following:

(1) the date of issue;

(2) the name and address of the patient;

(3) the name and quantity of the drug prescribed;

(4) directions for use; and

(5) the name, and address ~~, and telephone number~~ of the prescribing physician assistant ~~and of the physician serving as supervisor~~.

(d) In prescribing, dispensing, and administering legend drugs and medical devices, including controlled substances as defined in section 152.01, subdivision 4, a physician assistant must conform with the agreement, chapter 151, and this chapter.

Sec. 3. Minnesota Statutes 2004, section 147C.05, is amended to read:

147C.05 [SCOPE OF PRACTICE.]

(a) The practice of respiratory care by a registered

respiratory care practitioner includes, but is not limited to, the following services:

(1) providing and monitoring therapeutic administration of medical gases, aerosols, humidification, and pharmacological agents related to respiratory care procedures, but not including administration of general anesthesia;

(2) carrying out therapeutic application and monitoring of mechanical ventilatory support;

(3) providing cardiopulmonary resuscitation and maintenance of natural airways and insertion and maintenance of artificial airways;

(4) assessing and monitoring signs, symptoms, and general behavior relating to, and general physical response to, respiratory care treatment or evaluation for treatment and diagnostic testing, including determination of whether the signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics;

(5) obtaining physiological specimens and interpreting physiological data including:

(i) analyzing arterial and venous blood gases;

(ii) assessing respiratory secretions;

(iii) measuring ventilatory volumes, pressures, and flows;

(iv) testing pulmonary function;

(v) testing and studying the cardiopulmonary system; and

(vi) diagnostic testing of breathing patterns related to sleep disorders;

(6) assisting hemodynamic monitoring and support of the cardiopulmonary system;

(7) assessing and making suggestions for modifications in the treatment regimen based on abnormalities, protocols, or changes in patient response to respiratory care treatment;

(8) providing cardiopulmonary rehabilitation including respiratory-care related educational components, postural drainage, chest physiotherapy, breathing exercises, aerosolized administration of medications, and equipment use and maintenance;

(9) instructing patients and their families in techniques for the prevention, alleviation, and rehabilitation of deficiencies, abnormalities, and diseases of the cardiopulmonary system; and

(10) transcribing and implementing physician orders for respiratory care services.

(b) Patient service by a practitioner must be limited to:

(1) services within the training and experience of the practitioner; and

(2) services within the parameters of the laws, rules, and standards of the facilities in which the respiratory care practitioner practices.

(c) Respiratory care services provided by a registered respiratory care practitioner, whether delivered in a health care facility or the patient's residence, must not be provided except upon referral from a physician.

(d) This section does not prohibit an individual licensed or registered as a respiratory therapist in another state or country from providing respiratory care in an emergency in this state, providing respiratory care as a member of an organ harvesting team, or from providing respiratory care on board an ambulance as part of an ambulance treatment team.

ARTICLE 7

COMMISSIONER OF HEALTH - AUDIOLOGISTS

Section 1. Minnesota Statutes 2004, section 148.512, subdivision 6, is amended to read:

Subd. 6. [AUDIOLOGIST.] "Audiologist" means a natural person who engages in the practice of audiology, meets the qualifications required by sections 148.511 to ~~148.5196~~ 148.5198, and is licensed by the commissioner under a general, clinical fellowship, doctoral externship, or temporary license. Audiologist also means a natural person using any descriptive word with the title audiologist.

Sec. 2. Minnesota Statutes 2004, section 148.512, is amended by adding a subdivision to read:

Subd. 10a. [HEARING AID.] "Hearing aid" means an

instrument, or any of its parts, worn in the ear canal and designed to or represented as being able to aid or enhance human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold. Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically implanted hearing aids, and assistive listening devices not worn within the ear canal, are not hearing aids.

Sec. 3. Minnesota Statutes 2004, section 148.512, is amended by adding a subdivision to read:

Subd. 10b. [HEARING AID DISPENSING.] "Hearing aid dispensing" means making ear mold impressions, prescribing, or recommending a hearing aid, assisting the consumer in aid selection, selling hearing aids at retail, or testing human hearing in connection with these activities regardless of whether the person conducting these activities has a monetary interest in the sale of hearing aids to the consumer.

Sec. 4. Minnesota Statutes 2004, section 148.515, is amended by adding a subdivision to read:

Subd. 6. [AUDIOLOGIST EXAMINATION REQUIREMENTS.] (a) An audiologist who applies for licensure on or after August 1, 2005, must achieve a passing score on the examination described in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described in section 153A.14, subdivision 2h, paragraph (b).

(b) Paragraph (a) does not apply to an audiologist licensed by reciprocity who was licensed before August 1, 2005, in another jurisdiction.

(c) Audiologists are exempt from the written examination requirement in section 153A.14, subdivision 2h, paragraph (a), clause (1).

Sec. 5. Minnesota Statutes 2004, section 148.5194, is amended by adding a subdivision to read:

Subd. 7. [SURCHARGE.] A surcharge of $..... is added to the audiologist licensure fee for the period of .....

Sec. 6. Minnesota Statutes 2004, section 148.5195, subdivision 3, is amended to read:

Subd. 3. [GROUNDS FOR DISCIPLINARY ACTION BY COMMISSIONER.] The commissioner may take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request, via certified mail, by the commissioner or advisory council;

(3) performed services of a speech-language pathologist or audiologist in an incompetent or negligent manner;

(4) violated sections 148.511 to ~~148.5196~~ 148.5198;

(5) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(6) violated any state or federal law, rule, or regulation, and the violation is a felony or misdemeanor, an essential element of which is dishonesty, or which relates directly or indirectly to the practice of speech-language pathology or audiology. Conviction for violating any state or federal law which relates to speech-language pathology or audiology is necessarily considered to constitute a violation, except as provided in chapter 364;

(7) aided or abetted another person in violating any provision of sections 148.511 to ~~148.5196~~ 148.5198;

(8) been or is being disciplined by another jurisdiction, if any of the grounds for the discipline is the same or substantially equivalent to those under sections 148.511 to 148.5196;

(9) not cooperated with the commissioner or advisory council in an investigation conducted according to subdivision 1;

(10) advertised in a manner that is false or misleading;

(11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for

the health, welfare, or safety of a client;

(12) failed to disclose to the consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(13) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(14) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(15) performed services for a client who had no possibility of benefiting from the services;

(16) failed to refer a client for medical evaluation or to other health care professionals when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

~~(17) if the individual is a dispenser of hearing instruments as defined by section 153A.13, subdivision 5, had the certification required by chapter 153A, denied, suspended, or revoked according to chapter 153A;~~

~~(18)~~ used the term doctor of audiology, doctor of speech-language pathology, AuD, or SLPD without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools, the Council on Academic Accreditation in Audiology and Speech-Language Pathology, the United States Department of Education, or an equivalent; ~~or~~

~~(19)~~ (18) failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathology assistants~~.~~;

(19) prescribed or otherwise recommended to a consumer or potential consumer the use of a hearing aid, unless the prescription from a physician or recommendation from an audiologist is in writing, is based on an audiogram that is

delivered to the consumer or potential consumer when the prescription or recommendation is made, and bears the following information in all capital letters of 12-point or larger boldface type: "THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING AIDS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE";

(20) failed to give a copy of the audiogram, upon which the prescription or recommendation is based, to the consumer when the consumer requests a copy;

(21) failed to provide the consumer rights brochure required by section 148.5197, subdivision 3;

(22) failed to comply with restrictions on sales of hearing aids in sections 148.5197, subdivision 3, and 148.5198;

(23) failed to return a consumer's hearing aid used as a trade-in or for a discount in the price of a new hearing aid when requested by the consumer upon cancellation of the purchase agreement;

(24) failed to follow Food and Drug Administration or Federal Trade Commission regulations relating to dispensing hearing aids; or

(25) failed to dispense a hearing aid in a competent manner or without appropriate training.

Sec. 7. [148.5197] [HEARING AID DISPENSING.]

Subdivision 1. [CONTENT OF CONTRACTS.] Oral statements made by an audiologist regarding the provision of warranties, refunds, and service on the hearing aid or aids dispensed must be written on, and become part of, the contract of sale, specify the item or items covered, and indicate the person or business entity obligated to provide the warranty, refund, or service.

Subd. 2. [REQUIRED USE OF LICENSE NUMBER.] The audiologist's license number must appear on all contracts, bills of sale, and receipts used in the sale of hearing aids.

Subd. 3. [CONSUMER RIGHTS INFORMATION.] An audiologist shall, at the time of the recommendation or prescription, give a consumer rights brochure, prepared by the commissioner and containing information about legal requirements pertaining to

sales of hearing aids, to each potential buyer of a hearing aid. The brochure must contain information about the consumer information center described in section 153A.18. A sales contract for a hearing aid must note the receipt of the brochure by the buyer, along with the buyer's signature or initials.

Subd. 4. [LIABILITY FOR CONTRACTS.] Owners of entities in the business of dispensing hearing aids, employers of audiologists or persons who dispense hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers conducting the sales transaction at issue are liable for satisfying all terms of contracts, written or oral, made by their agents, employees, assignees, affiliates, or trainees, including terms relating to products, repairs, warranties, service, and refunds. The commissioner may enforce the terms of hearing aid sales contracts against the principal, employer, supervisor, or dispenser who conducted the sale and may impose any remedy provided for in this chapter.

Sec. 8. [148.5198] [RESTRICTION ON SALE OF HEARING AIDS.]

Subdivision 1. [45-CALENDAR-DAY GUARANTEE AND BUYER RIGHT TO CANCEL.] (a) An audiologist dispensing a hearing aid in this state must comply with paragraphs (b) and (c).

(b) The audiologist must provide the buyer with a 45-calendar-day written money-back guarantee. The guarantee must permit the buyer to cancel the purchase for any reason within 45 calendar days after receiving the hearing aid by giving or mailing written notice of cancellation to the audiologist. If the consumer mails the notice of cancellation, the 45-calendar-day period is counted using the postmark date, to the date of receipt by the audiologist. If the hearing aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee period, the running of the 45-calendar-day period is suspended one day for each 24-hour period that the hearing aid is not in the buyer's possession. A repaired, remade, or adjusted hearing aid must be claimed by the buyer within three business days after notification of availability, after which time the running of the 45-calendar-day period

resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund of payment within 30 days of return of the hearing aid to the audiologist. The audiologist may retain as a cancellation fee no more than $250 of the buyer's total purchase price of the hearing aid.

(c) The audiologist shall provide the buyer with a contract written in plain English, that contains uniform language and provisions that meet the requirements under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must include, but is not limited to, the following: in immediate proximity to the space reserved for the signature of the buyer, or on the first page if there is no space reserved for the signature of the buyer, a clear and conspicuous disclosure of the following specific statement in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER RECEIPT OF THE HEARING AID(S). THIS CANCELLATION MUST BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST. IF THE BUYER DECIDES TO RETURN THE HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM WHICH THE AUDIOLOGIST MAY RETAIN AS A CANCELLATION FEE NO MORE THAN $250."

Subd. 2. [ITEMIZED REPAIR BILL.] Any audiologist or company who agrees to repair a hearing aid must provide the owner of the hearing aid, or the owner's representative, with a bill that describes the repair and services rendered. The bill must also include the repairing audiologist's or company's name, address, and telephone number.

This subdivision does not apply to an audiologist or company that repairs a hearing aid pursuant to an express warranty covering the entire hearing aid and the warranty covers the entire cost, both parts and labor, of the repair.

Subd. 3. [REPAIR WARRANTY.] Any guarantee of hearing aid repairs must be in writing and delivered to the owner of the hearing aid, or the owner's representative, stating the

repairing audiologist's or company's name, address, telephone number, length of guarantee, model, and serial number of the hearing aid and all other terms and conditions of the guarantee.

Subd. 4. [MISDEMEANOR.] A person found to have violated this section is guilty of a misdemeanor.

Subd. 5. [ADDITIONAL.] In addition to the penalty provided in subdivision 4, a person found to have violated this section is subject to the penalties and remedies provided in section 325F.69, subdivision 1.

Subd. 6. [ESTIMATES.] Upon the request of the owner of a hearing aid or the owner's representative for a written estimate and prior to the commencement of repairs, a repairing audiologist or company shall provide the customer with a written estimate of the price of repairs. If a repairing audiologist or company provides a written estimate of the price of repairs, it must not charge more than the total price stated in the estimate for the repairs. If the repairing audiologist or company after commencing repairs determines that additional work is necessary to accomplish repairs that are the subject of a written estimate and if the repairing audiologist or company did not unreasonably fail to disclose the possible need for the additional work when the estimate was made, the repairing audiologist or company may charge more than the estimate for the repairs if the repairing audiologist or company immediately provides the owner or owner's representative a revised written estimate pursuant to this section and receives authorization to continue with the repairs. If continuation of the repairs is not authorized, the repairing audiologist or company shall return the hearing aid as close as possible to its former condition and shall release the hearing aid to the owner or owner's representative upon payment of charges for repairs actually performed and not in excess of the original estimate.

Sec. 9. Minnesota Statutes 2004, section 153A.13, subdivision 5, is amended to read:

Subd. 5. [DISPENSER OF HEARING INSTRUMENTS.] "Dispenser of hearing instruments" means a natural person who engages in

hearing instrument dispensing whether or not certified by the commissioner of health or licensed by an existing health-related board, except that a person described as follows is not a dispenser of hearing instruments:

(1) a student participating in supervised field work that is necessary to meet requirements of an accredited educational program if the student is designated by a title which clearly indicates the student's status as a student trainee; or

(2) a person who helps a dispenser of hearing instruments in an administrative or clerical manner and does not engage in hearing instrument dispensing.

A person who offers to dispense a hearing instrument, or a person who advertises, holds out to the public, or otherwise represents that the person is authorized to dispense hearing instruments must be certified by the commissioner except when the person is an audiologist as defined in section 148.512.

Sec. 10. Minnesota Statutes 2004, section 153A.14, subdivision 2i, is amended to read:

Subd. 2i. [CONTINUING EDUCATION REQUIREMENT.] On forms provided by the commissioner, each certified dispenser must submit with the application for renewal of certification evidence of completion of ten course hours of continuing education earned within the 12-month period of July 1 to June 30 immediately preceding renewal. Continuing education courses must be directly related to hearing instrument dispensing and approved by the International Hearing Society ~~or qualify for continuing education approved for Minnesota licensed audiologists~~. Evidence of completion of the ten course hours of continuing education must be submitted with renewal applications by October 1 of each year. This requirement does not apply to dispensers certified for less than one year. The first report of evidence of completion of the continuing education credits shall be due October 1, 1997.

Sec. 11. Minnesota Statutes 2004, section 153A.14, subdivision 4, is amended to read:

Subd. 4. [DISPENSING OF HEARING INSTRUMENTS WITHOUT

CERTIFICATE.] Except as provided in subdivisions 2a, 4a, and 4c, it is unlawful for any person not holding a valid certificate to dispense a hearing instrument as defined in section 153A.13, subdivision 3. A person who dispenses a hearing instrument without the certificate required by this section is guilty of a gross misdemeanor.

Sec. 12. Minnesota Statutes 2004, section 153A.14, subdivision 4c, is amended to read:

Subd. 4c. [RECIPROCITY.] (a) A person applying for certification as a hearing instrument dispenser under subdivision 1 who has dispensed hearing instruments in another jurisdiction may dispense hearing instruments as a trainee under indirect supervision if the person:

(1) satisfies the provisions of subdivision 4a, paragraph (a);

(2) submits a signed and dated affidavit stating that the applicant is not the subject of a disciplinary action or past disciplinary action in this or another jurisdiction and is not disqualified on the basis of section 153A.15, subdivision 1; and

(3) provides a copy of a current credential as a hearing instrument dispenser~~, an audiologist, or both~~ held in the District of Columbia or a state or territory of the United States.

(b) A person becoming a trainee under this subdivision who fails to take and pass the practical examination described in subdivision 2h, paragraph (a), clause (2), when next offered must cease dispensing hearing instruments unless under direct supervision.

Sec. 13. Minnesota Statutes 2004, section 153A.15, subdivision 1, is amended to read:

Subdivision 1. [PROHIBITED ACTS.] The commissioner may take enforcement action as provided under subdivision 2 against a dispenser of hearing instruments for the following acts and conduct:

(1) prescribing or otherwise recommending to a consumer or potential consumer the use of a hearing instrument, unless the

prescription from a physician or recommendation from a hearing instrument dispenser or audiologist is in writing, is based on an audiogram that is delivered to the consumer or potential consumer when the prescription or recommendation is made, and bears the following information in all capital letters of 12-point or larger boldface type: "THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING INSTRUMENTS MAY BE PURCHASED FROM, THE CERTIFIED DISPENSER OR LICENSED AUDIOLOGIST OF YOUR CHOICE";

(2) failing to give a copy of the audiogram, upon which the prescription or recommendation is based, to the consumer when there has been a charge for the audiogram and the consumer requests a copy;

(3) dispensing a hearing instrument to a minor person 18 years or younger unless evaluated by an audiologist for hearing evaluation and hearing aid evaluation;

(4) failing to provide the consumer rights brochure required by section 153A.14, subdivision 9;

(5) being disciplined through a revocation, suspension, restriction, or limitation by another state for conduct subject to action under this chapter;

(6) presenting advertising that is false or misleading;

(7) providing the commissioner with false or misleading statements of credentials, training, or experience;

(8) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a consumer;

(9) splitting fees or promising to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(10) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(11) obtaining money, property, or services from a consumer through the use of undue influence, high pressure sales tactics,

harassment, duress, deception, or fraud;

(12) failing to comply with restrictions on sales of hearing aids in sections 153A.14, subdivision 9, and 153A.19;

(13) performing the services of a certified hearing instrument dispenser in an incompetent or negligent manner;

(14) failing to comply with the requirements of this chapter as an employer, supervisor, or trainee;

(15) failing to provide information in a timely manner in response to a request by the commissioner, commissioner's designee, or the advisory council;

(16) being convicted within the past five years of violating any laws of the United States, or any state or territory of the United States, and the violation is a felony, gross misdemeanor, or misdemeanor, an essential element of which relates to hearing instrument dispensing, except as provided in chapter 364;

(17) failing to cooperate with the commissioner, the commissioner's designee, or the advisory council in any investigation;

(18) failing to perform hearing instrument dispensing with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(19) failing to fully disclose actions taken against the applicant or the applicant's legal authorization to dispense hearing instruments in this or another state;

(20) violating a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the applicant in hearing instrument dispensing;

(21) having been or being disciplined by the commissioner of the Department of Health, or other authority, in this or another jurisdiction, if any of the grounds for the discipline are the same or substantially equivalent to those in sections 153A.13 to 153A.19;

(22) misrepresenting the purpose of hearing tests, or in any way communicating that the hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a

medical evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a test to select a hearing instrument, except that the hearing instrument dispenser can determine the need for or recommend the consumer obtain a medical evaluation consistent with requirements of the United States Food and Drug Administration;

(23) violating any of the provisions of sections 153A.13 to 153A.19; and

(24) aiding or abetting another person in violating any of the provisions of sections 153A.13 to 153A.19.

Sec. 14. Minnesota Statutes 2004, section 153A.20, subdivision 1, is amended to read:

Subdivision 1. [MEMBERSHIP.] The commissioner shall appoint nine persons to a Hearing Instrument Dispenser Advisory Council.

(a) The nine persons must include:

(1) three public members, as defined in section 214.02. At least one of the public members shall be a hearing instrument user and one of the public members shall be either a hearing instrument user or an advocate of one; and

(2) three hearing instrument dispensers certified under sections 153A.14 to 153A.20, each of whom is currently, and has been for the five years immediately preceding their appointment, engaged in hearing instrument dispensing in Minnesota and who represent the occupation of hearing instrument dispensing and who are not audiologists; and

(3) three audiologists ~~who are certified hearing instrument dispensers or are~~ licensed as audiologists under chapter 148.

(b) The factors the commissioner may consider when appointing advisory council members include, but are not limited to, professional affiliation, geographical location, and type of practice.

(c) No two members of the advisory council shall be employees of, or have binding contracts requiring sales exclusively for, the same hearing instrument manufacturer or the same employer.

Sec. 15. [REVISOR'S INSTRUCTION.]

The revisor of statutes shall change references from "sections 148.511 to 148.5196" to "sections 148.511 to 148.5198" wherever they appear in Minnesota Statutes and Minnesota Rules.

Sec. 16. [REPEALER.]

Minnesota Statutes 2004, section 153A.14, subdivision 2a, is repealed.

Sec. 17. [EFFECTIVE DATE.]

Sections 1 to 14 and 16 are effective August 1, 2005.

ARTICLE 8

OFFICE OF MENTAL HEALTH PRACTICES COMMITTEE

Section 1. Minnesota Statutes 2004, section 148B.60, is amended to read:

148B.60 [DEFINITIONS.]

Subdivision 1. [TERMS.] As used in sections 148B.60 to 148B.71, the following terms have the meanings given them in this section.

Subd. 2. [OFFICE OF MENTAL HEALTH PRACTICE OR OFFICE.] "Office of Mental Health Practice" or "office" means the Office of Mental Health Practice ~~established~~ authorized in section 148B.61.

Subd. 3. [UNLICENSED MENTAL HEALTH PRACTITIONER OR PRACTITIONER.] "Unlicensed mental health practitioner" or "practitioner" means a person who provides or purports to provide, for remuneration, mental health services as defined in subdivision 4. It does not include persons licensed by the Board of Medical Practice under chapter 147 or registered by the Board of Medical Practice under chapter 147A; the Board of Nursing under sections 148.171 to 148.285; the Board of Psychology under sections 148.88 to 148.98; the Board of Social Work under sections 148B.18 to 148B.289; the Board of Marriage and Family Therapy under sections 148B.29 to 148B.39; the Board of Behavioral Health and Therapy under sections 148B.50 to 148B.593 and chapter 148C; or another licensing board if the person is practicing within the scope of the license; members of the clergy who are providing pastoral services in the context of

performing and fulfilling the salaried duties and obligations required of a member of the clergy by a religious congregation; American Indian medicine men and women; licensed attorneys; probation officers; licensed school counselors employed by a school district while acting within the scope of employment as school counselors; ~~registered~~ licensed occupational therapists; or licensed occupational therapy assistants. For the purposes of complaint investigation or disciplinary action relating to an individual practitioner, the term includes:

(1) persons employed by a program licensed by the commissioner of human services who are acting as mental health practitioners within the scope of their employment;

(2) persons employed by a program licensed by the commissioner of human services who are providing chemical dependency counseling services; persons who are providing chemical dependency counseling services in private practice; and

(3) clergy who are providing mental health services that are equivalent to those defined in subdivision 4.

Subd. 4. [MENTAL HEALTH SERVICES.] "Mental health services" means psychotherapy, behavioral health care, spiritual counseling, hypnosis when not for entertainment, and the professional assessment, treatment, or counseling of another person for a cognitive, behavioral, emotional, social, or mental condition, symptom, or dysfunction, including intrapersonal or interpersonal dysfunctions. The term does not include pastoral services provided by members of the clergy to members of a religious congregation in the context of performing and fulfilling the salaried duties and obligations required of a member of the clergy by that religious congregation.

Subd. 5. [MENTAL HEALTH CLIENT OR CLIENT.] "Mental health client" or "client" means a person who receives or pays for the services of a mental health practitioner.

Subd. 5a. [MENTAL-HEALTH-RELATED LICENSING BOARDS.] "Mental-health-related licensing boards" means the Boards of Medical Practice, Nursing, Psychology, Social Work, Marriage and Family Therapy, and Behavioral Health and Therapy.

~~Subd. 7. [COMMISSIONER.] "Commissioner" means the commissioner of health or the commissioner's designee.~~

Subd. 7a. [COMMITTEE.] "Committee" means the Office of Mental Health Practices Committee, consisting of one person appointed by each of the following licensing boards: the Board of Medical Practice; the Board of Nursing; the Board of Psychology; the Board of Social Work; the Board of Marriage and Family Therapy; and the Board of Behavioral Health and Therapy.

Subd. 8. [DISCIPLINARY ACTION.] "Disciplinary action" means an adverse action taken by the commissioner against an unlicensed mental health practitioner relating to the person's right to provide mental health services.

Sec. 2. Minnesota Statutes 2004, section 148B.61, is amended to read:

148B.61 [OFFICE OF MENTAL HEALTH PRACTICE.]

Subdivision 1. [~~CREATION~~ AUTHORITY.] (a) The Office of Mental Health Practice is ~~created in the Department of Health~~ transferred to the mental-health-related licensing boards and authorized to investigate complaints and take and enforce disciplinary actions against all unlicensed mental health practitioners for violations of prohibited conduct, as defined in section 148B.68.

(b) The office shall publish a complaint telephone number, provide an informational Web site, and also serve as a referral point and clearinghouse on complaints against mental health ~~services and both licensed and unlicensed mental health professionals, through the dissemination of~~ practitioners. The office shall disseminate objective information to consumers ~~and~~ through the development and performance of public education activities, including outreach, regarding the provision of mental health services and both licensed and unlicensed mental health professionals who provide these services.

~~Subd. 2. [RULEMAKING.] The commissioner of health shall adopt rules necessary to implement, administer, or enforce provisions of sections 148B.60 to 148B.71 pursuant to chapter 14. The commissioner may not adopt rules that restrict or~~

~~prohibit persons from providing mental health services on the basis of education, training, experience, or supervision.~~

Subd. 4. [MANAGEMENT, REPORT, AND SUNSET OF THE OFFICE.] (a) The committee shall:

(1) designate one board to provide administrative management of the program;

(2) set the program budget; and

(3) ensure that the program's direction is in accord with its authority.

(b) If the participating boards change which board is designated to provide administrative management of the program, any appropriation remaining for the program shall transfer to the newly designated board on the effective date of the change. The participating boards must inform the appropriate legislative committees and the commissioner of finance of any change in the designated board and the amount of any appropriation transferred under this provision.

(c) The designated board shall hire the office employees and pay expenses of the program from funds appropriated for that purpose.

(d) After July 1, 2008, the committee shall prepare and submit a report to the legislature by January 15, 2009, evaluating the activity of the office and making recommendations concerning the regulation of unlicensed mental health practitioners. In the absence of legislative action to continue the office, the committee and the office expire on June 30, 2009.

Sec. 3. Laws 2003, chapter 118, section 29, as amended by Laws 2004, chapter 279, article 5, section 10, is amended to read:

Sec. 29. [REPEALER.]

(a) Minnesota Statutes ~~2002~~, sections 148B.60; 148B.61; 148B.63; 148B.64; 148B.65; 148B.66; 148B.67; 148B.68; 148B.69; 148B.70; and 148B.71, are repealed.

[EFFECTIVE DATE.] This paragraph is effective July 1, ~~2005~~ 2009.

(b) Minnesota Statutes 2002, section 148C.01, subdivision

6, is repealed.

[EFFECTIVE DATE.] This paragraph is effective July 1, 2005.

Sec. 4. [APPROPRIATION.]

$..... is appropriated from the state government special revenue fund to the mental-health-related licensing boards as nonrecovery funds.

Sec. 5. [REVISOR INSTRUCTION.]

The revisor of statutes shall insert "committee" or "committee's" wherever "commissioner of health" or "commissioner's" appears in Minnesota Statutes, sections 148B.60 to 148B.71.

Sec. 6. [EFFECTIVE DATE.]

This act is effective July 1, 2005.

ARTICLE 9

MISCELLANEOUS

Section 1. Minnesota Statutes 2004, section 148.5194, is amended by adding a subdivision to read:

Subd. 7. [PENALTY FEES.] (a) The penalty fee for practicing speech language pathology or audiology without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty fee for applicants who engage in the unauthorized practice of speech language pathology or audiology before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months. This paragraph does not apply to applicants not qualifying for a license who engage in the unauthorized practice of speech language pathology or audiology.

(c) The penalty fee for failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $100 plus $20 for each missing clock hour. The licensee must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by licensees prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. For conduct described in paragraph (a) or (b) occurring after August 1, 2005, and exceeding six months, payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 2. Minnesota Statutes 2004, section 148.6445, is amended by adding a subdivision to read:

Subd. 11. [PENALTY FEES.] (a) The penalty fee for practicing occupational therapy without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty fee for applicants who engage in the unauthorized practice of occupational therapy before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months. This paragraph does not apply to applicants not qualifying for a license who engage in the unauthorized practice of occupational therapy.

(c) The penalty fee for failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $100 plus $20 for each missing clock hour. The licensee must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by licensees prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. For conduct described in paragraph (a) or (b) occurring after August 1, 2005, and exceeding six months, payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 3. Minnesota Statutes 2004, section 148C.12, is

amended by adding a subdivision to read:

Subd. 11. [PENALTY FEES.] (a) The penalty fee for practicing alcohol and drug counseling without a current license after the credential has expired and before it is renewed is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any part of any subsequent month up to 36 months.

(b) The penalty fee for applicants who engage in the unauthorized practice of alcohol and drug counseling before being issued a license is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months. This paragraph does not apply to applicants not qualifying for a license who engage in the unauthorized practice of alcohol and drug counseling.

(c) The penalty fee for failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $100 plus $20 for each missing clock hour. The licensee must obtain the correct number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by licensees prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. For conduct described in paragraph (a) or (b) occurring after August 1, 2005, and exceeding 12 months, payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 4. [153A.175] [PENALTY FEES.]

(a) The penalty fee for holding oneself out as a hearing instrument dispenser without a current certificate after the credential has expired and before it is renewed is one-half the amount of the certificate renewal fee for any part of the first day, plus one-half the certificate renewal fee for any part of any subsequent days up to 30 days.

(b) The penalty fee for applicants who hold themselves out as hearing instrument dispensers after expiration of the trainee

period and before being issued a certificate is one-half the amount of the certificate application fee for any part of the first day, plus one-half the certificate application fee for any part of any subsequent days up to 30 days. This paragraph does not apply to applicants not qualifying for a certificate who hold themselves out as hearing instrument dispensers.

(c) The penalty fee for failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $200 plus $200 for each missing clock hour. The certificate holder must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

APPENDIX
Repealed Minnesota Statutes for S1204-1

148B.18 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 148B.18 to 148B.289, the following terms have the meanings given them.

Subd. 2. **Accredited program of social work.** "Accredited program of social work" means a school of social work or other educational program that has been accredited by the Council on Social Work Education.

Subd. 2a. **Applicant.** "Applicant" means a person who has submitted an application, with the appropriate fee, for licensure, temporary licensure, or reinstatement of an expired license.

Subd. 3. **Board.** "Board" means the Board of Social Work created in section 148B.19.

Subd. 3a. **Client.** "Client" means an individual, couple, family, group, organization, or community that receives, received, or should have received services from an applicant or a licensee.

Subd. 4. **County agency social worker.** "County agency social worker" means an individual who is employed by a county social service agency in Minnesota in social work practice.

Subd. 4a. **Licensee.** "Licensee" means a person licensed by the board.

Subd. 5. **State agency social worker.** "State agency social worker" means an individual who is employed by a state social service agency in Minnesota in social work practice.

Subd. 8. **Private practice.** "Private practice" means social work practice conducted by a licensee practicing within the permissible scope of a license, as defined in subdivision 11, and under appropriate supervision, as defined in subdivisions 11 and 12, who is either self-employed, or a member of a partnership or of a group practice, rather than being employed by an agency, clinic, or other similar entity.

Subd. 9. **Psychotherapy.** "Psychotherapy" in clinical social work practice means the application of social work theory, methodology, and values in the treatment of a person or persons who have cognitive, emotional, behavioral, or social dysfunctions through psychosocial, psychological, or interpersonal methods. The treatment is a planned and structured program which is based on information from a differential diagnostic assessment, and is directed toward the accomplishment of goals provided in a plan of care. The person-in-situation/environment configuration is considered and integrated into the diagnosis and treatment. Psychotherapy may be conducted by licensed independent clinical social workers and by licensed graduate or licensed independent social workers who practice under the supervision of either a licensed independent clinical social worker or, if approved by the board, by another qualified mental health professional.

Subd. 10. **Qualified mental health professional.** "Qualified mental health professional" means a psychiatrist, board-certified or eligible for board certification, and licensed under chapter 147; a psychologist licensed under sections 148.88 to 148.98; an independent clinical social worker who has the qualifications in section 148B.21, subdivision 6; a psychiatric registered nurse with a master's degree from an accredited school of nursing, licensed under section 148.211, with at least two years of post-master's supervised experience in direct clinical practice; a marriage and family therapist who

is licensed under sections 148B.29 to 148B.39; or an equivalent mental health professional, as determined by the board, who is licensed or certified by a board or agency in another state or territory.

Subd. 11. **Social work practice.** (a) "Social work practice" is the application of social work theory, knowledge, methods, and ethics to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities, with particular attention to the person-in-environment configuration.

(b) For all levels of licensure, social work practice includes assessment, treatment planning and evaluation, case management, information and referral, counseling, advocacy, teaching, research, supervision, consultation, community organization, and the development, implementation, and administration of policies, programs, and activities.

(c) For persons licensed at the licensed independent clinical social worker level, and for persons licensed at either the licensed graduate social worker or the licensed independent social worker level who practice social work under the supervision of a licensed independent clinical social worker, social work practice includes the diagnosis and treatment of mental and emotional disorders in individuals, families, and groups. The treatment of mental and emotional disorders includes the provision of individual, marital, and group psychotherapy.

Subd. 12. **Supervision.** "Supervision" means the direction of social work practice in face-to-face sessions. Further standards for supervision shall be determined by the Board of Social Work. Supervision shall be provided:

(1) by a social worker licensed at least at the level of the worker being supervised and qualified under section 148B.21 to practice without supervision, except that a licensed graduate social worker may supervise a licensed social worker; or

(2) by another qualified professional or qualified mental health professional when the Board of Social Work determines that supervision by a social worker as required in clause (1) is unobtainable, or in other situations considered appropriate by the Board of Social Work.

Subd. 13. **Temporary licensee.** "Temporary licensee" means a person licensed by the board under section 148B.21, subdivision 7.

148B.185 APPLICABILITY.

Sections 148B.18 to 148B.289 apply to all applicants and licensees, to all persons practicing social work with clients in this state, and to persons engaged in the unauthorized practice of social work.

148B.19 BOARD OF SOCIAL WORK.

Subdivision 1. **Creation.** The Board of Social Work is created. The board consists of 15 members appointed by the governor. The members are:

(1) ten social workers licensed under sections 148B.18 to 148B.289; and

(2) five public members as defined in section 214.02.

Subd. 2. **Qualifications of board members.** Five of the social worker members of the board shall be licensed at the baccalaureate level of licensure and five shall be licensed at the master's level of licensure.

Eight of the social worker members shall be engaged in the

practice of social work in Minnesota in the following settings:

(1) one member shall be engaged in the practice of social work in a state agency;

(2) one member shall be engaged in the practice of social work in a county agency;

(3) two members shall be engaged in the practice of social work in a private agency;

(4) one member shall be engaged in the practice of social work in a private clinical social work setting;

(5) one member shall be an educator engaged in regular teaching duties at an accredited program of social work;

(6) one member shall be engaged in the practice of social work in an elementary, middle, or secondary school; and

(7) one member shall be employed in a hospital or nursing home licensed under chapter 144 or 144A.

In addition, at least five members shall be persons with expertise in communities of color and at least six members shall reside outside of the seven-county metropolitan area.

Subd. 4. **Officers and executive director.** The board shall annually elect from its membership a chair, vice-chair, and secretary-treasurer, and shall adopt rules to govern its proceedings. The board shall appoint and employ an executive director who is not a member of the board. The employment of the executive director shall be subject to the terms described in section 214.04, subdivision 2a.

Subd. 5. **Terms and salaries.** Chapter 214 applies to the Board of Social Work unless superseded by sections 148B.18 to 148B.289.

148B.20 DUTIES OF BOARD.

Subdivision 1. **General.** The Board of Social Work shall:

(a) Adopt and enforce rules for licensure of social workers and for regulation of their professional conduct. The rules must be designed to protect the public.

(b) Adopt rules establishing standards and methods of determining whether applicants and licensees are qualified under sections 148B.21 to 148B.24. The rules must make provision for examinations and must establish standards for professional conduct, including adoption of a code of professional ethics and requirements for continuing education.

(c) Hold examinations at least twice a year to assess applicants' knowledge and skills. The examinations may be written or oral and may be administered by the board or by a body designated by the board. Examinations must test the knowledge and skills of each of the four groups of social workers qualified under section 148B.21 to practice social work. Examinations must minimize cultural bias and must be balanced in theory.

(d) Issue licenses to individuals qualified under sections 148B.18 to 148B.24.

(e) Issue copies of the rules for licensure to all applicants.

(f) Establish and implement procedures, including a standard disciplinary process, to ensure that individuals licensed as social workers will comply with the board's rules.

(g) Establish, maintain, and publish annually a register of current licensees.

(h) Educate the public about the existence and content of the rules for social work licensing to enable consumers to file

complaints against licensees who may have violated the rules.

(i) Evaluate its rules in order to refine the standards for licensing social workers and to improve the methods used to enforce the board's standards.

Subd. 3. **Duties of board.** The board shall establish fees, including late fees, for licenses and renewals so that the total fees collected by the board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.1285. Fees must be credited to accounts in the special revenue fund.

148B.21 REQUIREMENTS FOR LICENSURE.

Subdivision 1. **Categories of licensees.** The board shall issue licenses for the following four groups of individuals qualified under this section to practice social work:

(1) social workers;

(2) graduate social workers;

(3) independent social workers; and

(4) independent clinical social workers.

Subd. 2. **Fee.** Each applicant shall pay a nonrefundable fee set by the board. Fees paid to the board shall be deposited in the state government special revenue fund.

Subd. 3. **Social worker.** (a) Except as provided in paragraph (b), to be licensed as a social worker, an applicant must provide evidence satisfactory to the board that the applicant:

(1) has received a baccalaureate degree from an accredited program of social work;

(2) has passed the examination provided for in section 148B.20, subdivision 1;

(3) will engage in social work practice only under supervision as defined in section 148B.18, subdivision 12, for at least two years in full-time employment or 4,000 hours of part-time employment;

(4) will conduct all professional activities as a social worker in accordance with standards for professional conduct established by the statutes and rules of the board; and

(5) has not engaged in conduct warranting a disciplinary action against a licensee. If the applicant has engaged in conduct warranting disciplinary action against a licensee, the board may issue a license only on the applicant's showing that the public will be protected through the issuance of a license with conditions or limitations approved by the board.

(b) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (2), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a social worker if the applicant:

(1) provides evidence satisfactory to the board of compliance with the requirements in paragraph (a), clauses (1), (3), (4), and (5); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2005.

Subd. 4. **Graduate social worker.** (a) Except as provided in paragraph (b), to be licensed as a graduate social worker, an applicant must provide evidence satisfactory to the board that the applicant:

(1) has received a master's degree from an accredited program of social work or doctoral degree in social work;

(2) has passed the examination provided for in section 148B.20, subdivision 1;

(3) will engage in social work practice only under supervision as defined in section 148B.18, subdivision 12;

(4) will conduct all professional activities as a graduate social worker in accordance with standards for professional conduct established by the statutes and rules of the board; and

(5) has not engaged in conduct warranting a disciplinary action against a licensee. If the applicant has engaged in conduct warranting disciplinary action against a licensee, the board may issue a license only on the applicant's showing that the public will be protected through the issuance of a license with conditions or limitations approved by the board.

(b) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (2), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as a graduate social worker if the applicant:

(1) provides evidence satisfactory to the board of compliance with the requirements in paragraph (a), clauses (1), (3), (4), and (5); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.

This paragraph expires August 1, 2005.

Subd. 5. **Independent social worker.** (a) Except as provided in paragraph (b), to be licensed as an independent social worker, an applicant must provide evidence satisfactory to the board that the applicant:

(1) has received a master's degree from an accredited program of social work or doctoral degree in social work;

(2) has passed the examination provided for in section 148B.20, subdivision 1;

(3) has practiced social work for at least two years in full-time employment or 4,000 hours of part-time employment under supervision as defined in section 148B.18, subdivision 12, after receiving the master's or doctoral degree in social work;

(4) will conduct all professional activities as an independent social worker in accordance with standards for professional conduct established by the statutes and rules of the board; and

(5) has not engaged in conduct warranting a disciplinary action against a licensee. If the applicant has engaged in conduct warranting disciplinary action against a licensee, the board may issue a license only on the applicant's showing that the public will be protected through the issuance of a license with conditions or limitations approved by the board.

(b) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (2), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as an independent social worker if the applicant:

(1) provides evidence satisfactory to the board of compliance with the requirements in paragraph (a), clauses (1), (3), (4), and (5); and

(2) provides to the board letters of recommendation and

experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.
This paragraph expires August 1, 2005.

Subd. 6. **Independent clinical social worker.** (a) Except as provided in paragraph (b), to be licensed as an independent clinical social worker, an applicant must provide evidence satisfactory to the board that the applicant:

(1) has received a master's degree from an accredited program of social work, or doctoral degree in social work, that included an advanced concentration of clinically oriented course work as defined by the board and a supervised clinical field placement at the graduate level, or post-master's clinical training that is found by the board to be equivalent to that course work and field placement;

(2) has practiced clinical social work for at least two years in full-time employment or 4,000 hours of part-time employment under supervision as defined in section 148B.18, subdivision 12, after receiving the master's or doctoral degree in social work;

(3) has passed the examination provided for in section 148B.20, subdivision 1;

(4) will conduct all professional activities as an independent clinical social worker in accordance with standards for professional conduct established by the statutes and rules of the board; and

(5) has not engaged in conduct warranting a disciplinary action against a licensee. If the applicant has engaged in conduct warranting disciplinary action against a licensee, the board may issue a license only on the applicant's showing that the public will be protected through the issuance of a license with conditions or limitations approved by the board.

(b) An applicant who was born in a foreign country, who has taken and failed to pass the examination specified in paragraph (a), clause (3), at least once since January 1, 2000, and for whom English is a second language, is eligible for licensure as an independent clinical social worker if the applicant:

(1) provides evidence satisfactory to the board of compliance with the requirements in paragraph (a), clauses (1), (2), (4), and (5); and

(2) provides to the board letters of recommendation and experience ratings from two licensed social workers and one professor from the applicant's social work program who can attest to the applicant's competence.
This paragraph expires August 1, 2005.

Subd. 6a. **Background checks.** The board shall request a criminal history background check from the superintendent of the Bureau of Criminal Apprehension on all applicants for initial licensure. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by applicants for criminal history background checks under this subdivision into the miscellaneous special revenue fund. The fees collected under this subdivision are appropriated to the board for the purpose of reimbursing the Bureau of Criminal Apprehension for the cost of the background checks upon their completion.

Subd. 7. **Temporary license.** (a) The board may issue

a temporary license to practice social work to an applicant who is either:

(1) not licensed in any jurisdiction but has:

(i) applied for a license under section 148B.24;

(ii) applied for a temporary license on a form provided by the board;

(iii) submitted a form provided by the board authorizing the board to complete a criminal background check with the Minnesota Bureau of Criminal Apprehension;

(iv) passed the applicable licensure examination provided for in section 148B.20, subdivision 1, paragraph (c); and

(v) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or master's degree from a social work program accredited by the Council on Social Work Education or the requirements for a doctoral degree in social work; or

(2) licensed in another jurisdiction, may or may not have applied for a license under section 148B.20, and has:

(i) applied for a temporary license on a form provided by the board;

(ii) submitted a form provided by the board authorizing the board to complete a criminal background check with the Minnesota Bureau of Criminal Apprehension;

(iii) submitted evidence satisfactory to the board that the applicant is currently licensed or credentialed to practice social work in another jurisdiction; and

(iv) attested on a form provided by the board that the applicant has completed the requirements for a baccalaureate or master's degree from a social work program accredited by the Council on Social Work Education or the requirements for a doctoral degree in social work.

(b) An applicant for a temporary license must not practice social work in Minnesota until the applicant has been granted a temporary license. An applicant who is practicing social work at the time of application is ineligible for a temporary license.

(c) An applicant for a temporary license must pay the nonrefundable application fee described in section 148B.226 plus the required fee for the cost of the criminal background check. Only one fee for the cost of the criminal background check must be submitted when the applicant is applying for both a temporary license and a license under section 148B.20.

(d) An applicant who is not licensed in another jurisdiction and who obtains a temporary license may practice social work only under the supervision of a licensed social worker who is eligible to provide supervision under section 148B.18, subdivision 12. The applicant's supervisor must provide evidence to the board, before the applicant is approved by the board for licensure, that the applicant has practiced social work under supervision. This supervision applies toward the supervision requirement required after licensure.

(e) A temporary licensee who has provided evidence to the board that the licensee has completed the requirements for a baccalaureate degree in social work from a social work program accredited by the Council on Social Work Education may temporarily engage in the social work practice described in section 148B.18, subdivision 11, paragraph (b), but may not engage in the social work practice described in section 148B.18, subdivision 11, paragraph (c).

(f) A temporary licensee who has provided evidence to the

board that the licensee has completed the requirements for a master's degree in social work from a social work program accredited by the Council on Social Work Education, or the requirements for a doctoral degree in social work, may temporarily engage in the social work practice described in section 148B.18, subdivision 11, paragraphs (b) and (c).

(g) A temporary licensee shall conduct all professional activities as a social worker in accordance with the requirements established by the statutes and rules of the board.

(h) A temporary licensee must use the title "Social Worker - Temporary Licensee" in all professional use of the temporary licensee's name.

(i) The board may immediately revoke the temporary license of any temporary licensee who violates any requirements of this subdivision. A temporary licensee whose temporary license is revoked shall immediately return the temporary license to the board.

(j) A temporary license is valid for six months, or until the board issues or denies a license, or until the board revokes the temporary license, whichever comes first, and is nonrenewable. An individual holding a temporary license may not practice social work for more than six months without a license under section 148B.24.

Subd. 8. **Change of licensure level.** An applicant who applies under this section for licensure as a licensed independent social worker or a licensed independent clinical social worker, and who is licensed at the time of application as a licensed graduate social worker, or a licensed independent social worker, is not required to meet the educational requirement of this section. The applicant must meet all other requirements for licensure at the new level of licensure.

Subd. 9. **Supervision requirement.** If supervised social work practice is required for licensure under this section, and if the applicant has not engaged in the practice of social work during the five years preceding the applicant's application for licensure, then the board may grant a conditional license to the applicant that would require that the applicant obtain additional social work supervision or additional continuing education hours, or both, within a specified time period after licensure. The board shall establish rules to implement this section.

148B.215 CONTESTED CASE HEARING.

An applicant or a licensee who is the subject of an adverse action by the board may request a contested case hearing under chapter 14. An applicant or a licensee who desires to request a contested case hearing must submit a written request to the board within 90 days of the date on which the board mailed the notification of the adverse action.

148B.22 LICENSE RENEWAL REQUIREMENTS.

Subdivision 1. **Renewal.** Licensees shall renew licenses at the time and in the manner established by the rules of the board.

Subd. 1a. **Reinstatement of expired licenses.** (a) The board must reinstate an expired license under either of the following conditions:

(1) hardship cases in which the applicant has:

(i) demonstrated to the board's satisfaction that the applicant was unable to comply with the board's license renewal requirements due to a mental or physical condition;

(ii) submitted an application for reinstatement on a form provided by the board;

(iii) paid the applicable hardship reinstatement fee described in section 148B.226, subdivision 2, paragraph (j);

(iv) demonstrated to the board's satisfaction that the applicant was in compliance with the board's continuing education requirements at the time the license expired; and

(v) if applicable, demonstrated to the board's satisfaction that the licensee is in compliance with the supervised practice requirements established by the board in rule and statute; or

(2) nonhardship cases in which the applicant has:

(i) submitted an application for reinstatement on a form provided by the board within one year of the date the license expired;

(ii) paid the applicable nonhardship reinstatement fee described in section 148B.226, subdivision 2, paragraph (k);

(iii) demonstrated to the board's satisfaction that the applicant was in compliance with the board's continuing education requirements at the time the license expired; and

(iv) if applicable, demonstrated to the board's satisfaction that the licensee is in compliance with the supervised practice requirements established by the board in rule and statute.

(b) When an applicant's expired license has been reinstated under paragraph (a), clause (1) or (2), the reinstated license is effective the day following the day the license expired.

(c) A licensee whose license expired on or after August 1, 2001, may apply for reinstatement of an expired license pursuant to paragraph (a), clause (2). The application must be submitted no later than July 31, 2004.

Subd. 2. **Continuing education.** At the time of renewal, each licensee shall provide evidence satisfactory to the board that the licensee has completed during each two-year period at least the equivalent of 30 clock hours of continuing professional postdegree education in programs approved by the board and continues to be qualified to practice under sections 148B.18 to 148B.289.

Subd. 3. **Background checks.** The board shall request a criminal history background check from the superintendent of the Bureau of Criminal Apprehension on all licensees under its jurisdiction who did not complete a criminal history background check as part of an application for initial licensure. This background check is a onetime requirement. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by licensees for criminal history background checks under this subdivision into the miscellaneous special revenue fund. The fees collected under this subdivision are appropriated to the board for the purpose of reimbursing the Bureau of Criminal Apprehension for the cost of the background checks upon their completion.

148B.224 ALTERNATIVE LICENSE STATUS.

Subdivision 1. **Defined; qualifications.** A license may be placed on inactive status if a licensee is not practicing social work in Minnesota and the licensee does not wish to meet license renewal requirements every two years. A licensee qualifies for inactive status if the licensee demonstrates to the board that the licensee is not practicing social work, as

defined by section 148B.18, in any setting in Minnesota.

Subd. 2. **Application.** (a) A licensee may apply for inactive status: (1) at any time by submitting a written application for inactive status; or (2) as an alternative to applying for the renewal of a license by so recording on the application for license renewal form and submitting the completed, signed form. The application for inactive status must be accompanied by the nonrefundable inactive status fee specified in section 148B.226, payable to the Board of Social Work. An application that is not completed or signed, or which is not accompanied by the correct inactive status fee, shall be returned to the licensee and is void. If the application for inactive status is received after the expiration date, the licensee shall pay a late fee as specified in section 148B.226, payable to the Board of Social Work, in addition to the inactive status fee, before the application for inactive status will be considered by the board.

(b) The licensee shall attest on a form provided by the board that the applicant will not use the title social worker and will not engage in social work practice in any setting in Minnesota after the date of the board's approval of the application for inactive status.

Subd. 3. **Approval.** The board shall approve an application for inactive status if the qualifications and application requirements have been met.

Subd. 4. **Practice prohibited.** Licensees on inactive status shall not practice, attempt to practice, offer to practice, or advertise or hold themselves out as authorized to practice social work in any setting in Minnesota and shall use only the title "Social Worker - Inactive Status."

Subd. 5. **Time limit on inactive status.** A licensee may maintain a license on inactive status for up to ten consecutive years. Within 30 days after the end of this ten-year period, the licensee must apply for reactivation of the license pursuant to subdivision 7 or the license expires. The board shall mail an application for reactivation to a licensee at least 45 days before the expiration date of the license. Placing the application for license reactivation in first class United States mail, addressed to the licensee at the licensee's last known mailing address with postage prepaid, constitutes valid mailing. Failure to receive the reactivation application does not release a license holder from the requirements of this section.

Subd. 6. **Continuing education requirement.** A licensee whose license is on inactive status must continue to obtain the continuing education hours required by rule that would be required if the licensee's license were on active status.

Subd. 7. **Reactivating a license.** (a) To reactivate a license, a licensee must complete an application for reactivation of a license, in a form specified by the board; document compliance with the continuing education hours required by subdivision 6 and any continuing education hours not reported by the last expiration date of the license; submit a supervision plan under rules of the board, if required; pay a prorated license renewal fee for the balance of the biennial renewal cycle; and pay the duplicate license certificate fee specified in section 148B.226, if the licensee needs a license in order to meet the requirements of Minnesota Rules, part 8740.0340,

subpart 4.

(b) If a licensee who reactivates a license has been on inactive status for five or more consecutive years and has not practiced social work during this period, the licensee must receive at least 38 hours of supervision for the first year of full-time practice or 2,000 hours of part-time practice, in accordance with the supervised practice requirements in rules of the board, for application to the licensee's current level. A licensee must submit a supervision plan before beginning practice, in accordance with rules of the board. A licensee must have the supervisor submit verification of the supervised practice in a form specified by the board within 30 days of completing this supervised practice requirement. This supervision requirement must be waived if the licensee can document at least two years of social work practice, outside of Minnesota, within the previous five-year period.

(c) For licensed social workers, the completed hours of supervised practice required under this subdivision apply toward any remaining hours required by Minnesota Rules, part 8740.0130, subpart 3.

(d) Licensed graduate social workers and licensed independent social workers shall complete this supervised practice requirement before applying for another social work license. Supervised practice hours obtained to meet this requirement may be applied toward the supervised practice requirement for another social work license.

Subd. 8. **License or renewal fee.** A licensee who is approved for inactive status before the end of the renewal cycle may not receive a refund for any portion of the license fee or renewal fee.

Subd. 9. **Disciplinary or corrective action.** The board shall retain jurisdiction over a license on inactive status and may take disciplinary or corrective action against the license based on conduct occurring before inactive status was granted or during the inactive status period.

148B.225 EMERITUS STATUS.

Subdivision 1. **Defined; qualifications.** A licensee may apply for an emeritus license if the licensee is retired from social work practice and does not intend to practice social work in any setting in Minnesota. A licensee shall qualify for an emeritus license if the licensee demonstrates to the board that the licensee is not practicing social work, as defined in section 148B.18, and verifies that the licensee is retired from social work practice.

Subd. 2. **Application.** (a) A licensee may apply for an emeritus license: (1) at any time by submitting a written application for an emeritus license; or (2) as an alternative to applying for the renewal of a license by so recording on the application for license renewal form and submitting a completed, signed form. The application for an emeritus license must be accompanied by the onetime, nonrefundable emeritus license fee specified in section 148B.226, payable to the Board of Social Work. An application which is not completed or signed, or which is not accompanied by the correct emeritus license fee, must be returned to the licensee and is void.

(b) An applicant for an emeritus license shall attest on a form provided by the board that the licensee will not use the title "social worker" and will not engage in social work practice in any setting in Minnesota after the date of the

board's approval of the application for an emeritus license.

Subd. 3. **Approval.** The board shall approve an application for an emeritus license if the qualifications and application requirements have been met. Upon approval of an application for an emeritus license, the board shall issue an emeritus license certificate.

Subd. 4. **Practice prohibited.** A licensee with an emeritus license shall not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work in any setting in Minnesota, and shall use only the title "social worker emeritus."

Subd. 5. **Reactivating a license.** A licensee with an emeritus license may reactivate a license by meeting the requirements of section 148B.224, subdivision 7.

Subd. 6. **License or renewal fee.** A licensee who applies for and is approved for an emeritus license before the end of the renewal cycle may not receive a refund for any portion of the license fee or renewal fee.

Subd. 7. **Disciplinary action.** (a) The board may resolve any pending complaints against a licensee before approving an application for an emeritus license.

(b) The board shall retain jurisdiction and may take disciplinary action against a licensee holding an emeritus license based on conduct occurring before issuance of the emeritus license.

148B.226 FEES.

Subdivision 1. **How payable.** The fees in subdivision 2 must be paid by personal check, bank draft, cashier's check, or money order payable to the Board of Social Work. All fees are nonrefundable.

Subd. 2. **Fee amounts.** (a) Application fees for licensure are as follows:

(1) for a licensed social worker or a licensed graduate social worker, $45;

(2) for a licensed independent social worker or a licensed independent clinical social worker, $90;

(3) for a reciprocity application for licensure at all levels, $150; and

(4) for a temporary license application, $50.

(b) A criminal background check fee must be paid in the amount determined by the Bureau of Criminal Apprehension.

(c) License fees payable in addition to application fees for licensure are as follows:

(1) licensed social worker, $115.20;
(2) licensed graduate social worker, $201.60;
(3) licensed independent social worker, $302.40; and
(4) licensed independent clinical social worker, $331.20.

(d) License renewal fees are as follows:

(1) licensed social worker, $115.20;
(2) licensed graduate social worker, $201.60;
(3) licensed independent social worker, $302.40; and
(4) licensed independent clinical social worker, $331.20.

(e) An emeritus license fee is $43.20.

(f) A duplicate license wall certificate is $30.

(g) Inactive status fees are as follows:

(1) licensed social worker, $115.20;
(2) licensed graduate social worker, $201.60;
(3) licensed independent social worker, $302.40; and
(4) licensed independent clinical social worker, $331.20.

(h) A duplicate license card is $10.

(i) A late fee is one-half of the applicable license renewal fee or inactive status fee.

(j) Hardship reinstatement fees are as follows:

(1) licensed social worker, $172.80;

(2) licensed graduate social worker, $302.40;

(3) licensed independent social worker, $453.60; and

(4) licensed independent clinical social worker, $496.80.

(k) Nonhardship reinstatement fees are as follows:

(1) licensed social worker, $230.40;

(2) licensed graduate social worker, $403.20;

(3) licensed independent social worker, $604.80; and

(4) licensed independent clinical social worker, $662.40.

148B.24 RECIPROCITY.

The board shall issue an appropriate license to an individual who holds a current license or other credential from another jurisdiction if the board finds that the requirements for that credential are substantially similar to the requirements in section 148B.21.

148B.25 NONTRANSFERABILITY OF LICENSES.

A social work license is not transferable.

148B.26 DENIAL, SUSPENSION, OR REVOCATION OF LICENSE.

Subdivision 1. **Grounds.** The following conduct is grounds for the board to deny the application for or the renewal of a temporary license, to take disciplinary or other action against a license as provided for in section 148B.281, or to take corrective action against a licensee as provided for in chapter 214:

(1) engaging in any conduct which violates any statute or rule enforced by the board, or any other law that is related to the practice of social work;

(2) violating any order issued by the board;

(3) practicing outside the scope of practice authorized by this chapter for each level of licensure;

(4) failing to demonstrate the qualifications or satisfy the requirements for licensure, with the burden of proof on the applicant to demonstrate the qualifications or the satisfaction of the requirements;

(5) obtaining a temporary license or license renewal by fraud, bribery, or cheating, or attempting to subvert the examination process;

(6) making a false statement or misrepresentation to the board;

(7) having been the subject of revocation, suspension, or surrender of a social work or related license or of other adverse action related to a social work or related license in another jurisdiction or country;

(8) failing to report the revocation, suspension, or surrender of a social work or related license or other adverse action related to a social work or related license in another jurisdiction or country, failing to report that a complaint or other charges regarding the person's license have been brought in this or another jurisdiction or country, or having been refused a license by any other jurisdiction or country;

(9) engaging in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;

(10) engaging in unethical conduct or conduct likely to deceive, defraud, or harm the public, demonstrating a willful or careless disregard for the health, welfare, or safety of a client, or engaging in a practice which is professionally incompetent with proof of actual injury not having to be established;

(11) being adjudicated by a court of competent jurisdiction, within or without this state, as incapacitated, mentally incompetent or mentally ill, chemically dependent, mentally ill and dangerous to the public, or a psychopathic personality;

(12) being 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 or physical condition;

(13) engaging in improper or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws;

(14) obtaining money, property, or services from a client through the use of undue influence, harassment, duress, deception, or fraud or through the improper use of a professional position;

(15) engaging in sexual contact, as defined in section 148A.01, with a client or conduct that is or may reasonably be interpreted by the client as sexual, engaging in verbal behavior that is or may reasonably be interpreted as sexually seductive or sexually demeaning to a client, or engaging in conduct that violates section 617.23;

(16) being convicted, including a finding or verdict of guilt, whether or not the adjudication of guilt is withheld or not entered, an admission of guilt, or a no contest plea, of a crime against a minor;

(17) being convicted, including a finding or verdict of guilt, whether or not the adjudication of guilt is withheld or not entered, an admission of guilt, or a no contest plea of a felony, gross misdemeanor, or misdemeanor reasonably related to the practice of social work, as evidenced by a certified copy of the conviction;

(18) engaging in an unfair discriminatory practice prohibited by chapter 363A of an employee of the applicant, licensee, or facility in which the applicant or licensee practices;

(19) engaging in false, fraudulent, deceptive, or misleading advertising; or

(20) revealing a privileged communication from or relating to a client except when otherwise required or permitted by law.

Subd. 2. **Restoring a license.** For reasons it finds sufficient, the board may grant a license previously refused, restore a license that has been revoked, or reduce a period of suspension or restriction of a license.

Subd. 3. **Review.** Suspension, revocation, or restriction of a license shall be reviewed by the board at the request of the licensee against whom the disciplinary action was taken.

Subd. 4. **Conduct before licensure.** The board's jurisdiction to exercise its powers as provided for in subdivision 1 extends to an applicant's or licensee's conduct that occurred prior to licensure, if the conduct fell below minimum standards for the practice of social work at the time

the conduct occurred or the conduct continues to affect the applicant's or licensee's present ability to practice social work in conformity with this chapter and the board's rules.

148B.27 PROHIBITION AGAINST UNLICENSED PRACTICE OR USE OF TITLES; PENALTY.

Subdivision 1. **Practice.** No individual shall engage in social work practice unless that individual holds a valid temporary license or a license as a licensed social worker, licensed graduate social worker, licensed independent social worker, or licensed independent clinical social worker.

Subd. 2. **Use of titles.** No individual shall be presented to the public by any title incorporating the words "social work" or "social worker" unless that individual holds a valid temporary license or a license issued under sections 148B.18 to 148B.289. City, county, and state agency social workers who are not licensed under sections 148B.18 to 148B.289 may use only the title city agency social worker or county agency social worker or state agency social worker.

Subd. 2a. **Jurisdiction.** Nothing in sections 148B.60 to 148B.71 shall prohibit the board from taking disciplinary or other action that the board is authorized to take against either a licensee who is found to be practicing outside the scope of the license or a person who is found to be engaging in the unauthorized practice of social work.

Subd. 2b. **Use of hospital social worker title.** Individuals employed as social workers on June 30, 1996, by a hospital licensed under chapter 144 who do not qualify for licensure under section 148B.21, may use the title "hospital social worker" for as long as they continue to be employed by a hospital licensed under chapter 144.

Subd. 3. **Penalty.** A person who violates sections 148B.21 to 148B.289 is guilty of a misdemeanor.

148B.28 EXCEPTIONS TO LICENSE REQUIREMENT.

Subdivision 1. **Other professionals.** Nothing in sections 148B.18 to 148B.289 shall be construed to prevent members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes but is not limited to licensed physicians; registered nurses; licensed practical nurses; psychological practitioners; probation officers; members of the clergy; attorneys; marriage and family therapists; chemical dependency counselors; professional counselors; school counselors; and registered occupational therapists or certified occupational therapist assistants. These persons must not, however, hold themselves out to the public by any title or description stating or implying that they are engaged in the practice of social work, or that they are licensed to engage in the practice of social work. Persons engaged in the practice of social work are not exempt from the board's jurisdiction solely by the use of one of the above titles.

Subd. 2. **Students.** An internship, externship, or any other social work experience that is required for the completion of an accredited program of social work does not constitute the practice of social work under this chapter.

Subd. 3. **Geographic waiver.** A geographic waiver may be granted by the board on a case-by-case basis to agencies with special regional hiring problems. The waiver will permit agencies to hire individuals, who do not meet the qualifications of section 148B.21, to practice social work.

Subd. 4. **City, county, and state agency social workers.** The licensing of city, county, and state agency social workers shall be voluntary. City, county, and state agencies employing social workers shall not be required to employ licensed social workers.

Subd. 5. **Federally recognized tribes and private nonprofit agencies with a minority focus.** The licensure of social workers who are employed by federally recognized tribes, or by private nonprofit agencies whose primary service focus addresses ethnic minority populations, and are themselves members of ethnic minority populations within said agencies, shall be voluntary.

148B.281 COMPLAINTS; INVESTIGATION AND HEARING.

Subdivision 1. **Discovery; subpoenas.** In all matters relating to its lawful regulatory activities, the board may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear to testify regarding any matter about which the person may be lawfully questioned or failing to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the board or by a subpoena of the board to do so may, upon application to the district court in any district, be ordered to comply with the subpoena or order. Any board member may administer oaths to witnesses or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a person it names anywhere within the state by any officer authorized to serve subpoenas or other process or paper in civil actions in the same manner as prescribed by law for service of process issued out of the district court of this state.

Subd. 2. **Classification of data.** The board shall maintain any records, other than client records, obtained as part of an investigation, as investigative data under section 13.41. Client records are classified as private under chapter 13, and must be protected as such in the records of the board and in administrative or judicial proceedings unless the client authorizes the board in writing to make public the identity of the client or a portion or all of the client's records.

Subd. 3. **Examination.** If the board has probable cause to believe that an applicant or licensee has engaged in conduct prohibited by chapter 214 or a statute or rule enforced by the board, it may issue an order directing the applicant or licensee to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this section, every applicant or licensee is considered to have consented to submit to a mental or physical examination or chemical dependency evaluation when ordered to do so in writing by the board and to have waived all objections to the admissibility of the examiner's or evaluator's testimony or reports on the grounds that the testimony or reports constitute a privileged communication.

Subd. 4. **Failure to submit to an examination.** Failure to submit to an examination or evaluation when ordered, unless the failure was due to circumstances beyond the control of the applicant or licensee, constitutes an admission that the applicant or licensee violated chapter 214 or a statute or rule

enforced by the board, based on the factual specifications in the examination or evaluation order, and may result in an application being denied or a default and final disciplinary order being entered without the taking of testimony or other evidence. If a contested case hearing is requested, the only issues to be determined at the hearing are whether the designated board member had probable cause to issue the examination or evaluation order and whether the failure to submit was due to circumstances beyond the control of the applicant or licensee. Neither the record of a proceeding under this subdivision nor the orders entered by the board are admissible, subject to subpoena, or to be used against the applicant or licensee in a proceeding in which the board is not a party or decision maker. Information obtained under this subdivision is classified as private under chapter 13 and the orders issued by the board as the result of an applicant's or a licensee's failure to submit to an examination or evaluation are classified as public.

Subd. 5. **Access to data and records.** In addition to ordering a physical or mental examination or chemical dependency evaluation and notwithstanding section 13.384, 144.651, 595.02, or any other law limiting access to medical or other health records, the board may obtain data and health records relating to an applicant or licensee without the applicant's or licensee's consent if the board has probable cause to believe that an applicant or licensee has engaged in conduct prohibited by chapter 214 or a statute or rule enforced by the board. An applicant, licensee, insurance company, health care facility, provider as defined in section 144.335, subdivision 1, paragraph (b), or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released in accordance with a written request made under this subdivision, unless the information is false and the person or entity giving the information knew or had reason to know that the information was false. Information on individuals obtained under this section is investigative data under section 13.41.

Subd. 6. **Forms of disciplinary action.** When grounds for disciplinary action exist under chapter 214 or a statute or rule enforced by the board, it may take one or more of the following disciplinary actions:

(1) deny the right to practice;

(2) revoke the right to practice;

(3) suspend the right to practice;

(4) impose limitations on the practice of the licensee;

(5) impose conditions on the practice of the licensee;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the licensee of any economic advantage gained by reason of the violation charged, or to discourage repeated violations;

(7) impose a fee to reimburse the board for all or part of the cost of the proceedings resulting in disciplinary action including, but not limited to, the amount paid by the board for services from the Office of Administrative Hearings, attorney fees, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and expense incurred by board members and staff;

(8) censure or reprimand the licensee;

(9) require the passing of the examination provided for in section 148B.20, subdivision 1; or

(10) take any other action justified by the facts of the case.

Subd. 7. **Censure or reprimand.** (a) In addition to the board's authority to issue a censure or a reprimand to a licensee, a designated board member reviewing a complaint as provided for in chapter 214 may issue a censure or a reprimand to a licensee. The censure or reprimand shall notify the licensee that the censure or reprimand will become final disciplinary action unless the licensee requests a hearing within 14 days.

(b) If the licensee requests a timely hearing, the committee shall either schedule a hearing or withdraw the censure or reprimand. The hearing shall be de novo before the board, provided that the designated board member who issued the censure or reprimand shall not deliberate or vote. Evidence shall be received only in form of affidavits or other documents except for testimony by the licensee or other witnesses whose testimony the board chair has authorized for good cause. If testimony is authorized, it shall be subject to cross-examination. After the hearing, the board shall affirm or dismiss the censure or reprimand, or direct the committee to initiate a contested case proceeding pursuant to chapter 14.

Subd. 8. **Temporary suspension.** In addition to any other remedy provided by law, the board may, acting through its designated board member and without a hearing, temporarily suspend the right of a licensee to practice if the board member finds that the licensee has violated a statute or rule that the board is empowered to enforce and that continued practice by the licensee would create a serious risk of harm to others. The suspension is in effect upon service of a written order on the licensee specifying the statute or rule violated. The order remains in effect until the board issues a final order in the matter after a hearing or upon agreement between the board and the licensee. Service of the order is effective if the order is served on the licensee or counsel of record personally or by first class mail to the most recent address provided to the board for the licensee or the counsel of record. Within ten days of service of the order, the board shall hold a hearing before its own members on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the board or licensee may be in affidavit form only. The licensee or the counsel of record may appear for oral argument. Within five working days after the hearing, the board shall issue its order and, if the suspension is continued, schedule a contested case hearing within 45 days after issuance of the order. The administrative law judge shall issue a report within 30 days after closing of the contested case hearing record. The board shall issue a final order within 30 days after receipt of that report.

Subd. 9. **Automatic suspension; restoration.** The right to practice is automatically suspended if (1) a guardian of a licensee is appointed by order of a court under sections 524.5-101 to 524.5-502, or (2) the licensee is committed by order of a court pursuant to chapter 253B. The right to practice remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated

by the board after a hearing or upon agreement between the board and the licensee. In its discretion, the board may restore and reissue permission to provide services, but as a condition of the permission may impose a disciplinary or corrective measure that it might originally have imposed.

Subd. 10. **Additional remedies.** The board may in its own name issue a cease and desist order to stop a person from engaging in an unauthorized practice or violating or threatening to violate a statute, rule, or order which the board has issued or is empowered to enforce. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If, within 15 days of service of the order, the subject of the order fails to request a hearing in writing, the order is the final order of the board and is not reviewable by a court or agency.

A hearing must be initiated by the board not later than 30 days from the date of the board's receipt of a written hearing request. Within 30 days of receipt of the administrative law judge's report, the board shall issue a final order modifying, vacating, or making permanent the cease and desist order as the facts require. The final order remains in effect until modified or vacated by the board.

When a request for a stay accompanies a timely hearing request, the board may, in its discretion, grant the stay. If the board does not grant a requested stay, it shall refer the request to the Office of Administrative Hearings within three working days of receipt of the request. Within ten days after receiving the request from the board, an administrative law judge shall issue a recommendation to grant or deny the stay. The board shall grant or deny the stay within five days of receiving the administrative law judge's recommendation.

In the event of noncompliance with a cease and desist order, the board may institute a proceeding in Ramsey County District Court to obtain injunctive relief or other appropriate relief, including a civil penalty payable to the board not exceeding $10,000 for each separate violation.

Subd. 11. **Injunctive relief.** In addition to any other remedy provided by law, including the issuance of a cease and desist order under subdivision 1, the board may in its own name bring an action in Ramsey County District Court for injunctive relief to restrain any unauthorized practice or violation or threatened violation of any statute, rule, or order which the board is empowered to regulate, enforce, or issue. A temporary restraining order must be granted in the proceeding if continued activity by a licensee would create a serious risk of harm to others. The board need not show irreparable harm.

Subd. 12. **Additional powers.** The issuance of a cease and desist order or injunctive relief granted under this section does not relieve a licensee from criminal prosecution by a competent authority or from disciplinary action by the board. Nothing in this section limits the board's authority to seek injunctive relief under section 214.11.

Subd. 13. **Pending appeal.** A suspension, revocation, condition, limitation, qualification, or restriction of an individual's license or right to practice is in effect pending determination of an appeal unless the court, upon petition and for good cause shown, orders otherwise.

Subd. 14. **Duty to warn.** Section 148.975 applies to

social work licensees and clients.

148B.282 PROFESSIONAL COOPERATION; APPLICANT OR LICENSEE.

An applicant or a licensee who is the subject of an investigation, or who is questioned in connection with an investigation, by or on behalf of the board shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation, providing copies of client and other records in the applicant's or licensee's possession relating to the matter under investigation and executing releases for records, as reasonably requested by the board, and appearing at conferences or hearings scheduled by the board. The board shall pay for copies requested. The board shall be allowed access to any records of a client provided services by the applicant or licensee under review. If the client has not signed a consent permitting access to the client's records, the applicant or licensee shall delete any data in the record that identifies the client before providing them to the board. The board shall maintain any records obtained pursuant to this section as investigative data pursuant to chapter 13.

148B.283 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct by an applicant or a licensee which may constitute grounds for disciplinary action under this chapter or the rules of the board or of any unlicensed practice under this chapter may report the violation to the board.

Subd. 2. **Institutions.** A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the agency, institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition an applicant's or a licensee's privilege to practice or treat patients or clients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action for conduct that might constitute grounds for disciplinary action by the board under this chapter. The institution or organization shall also report the resignation of any applicants or licensees prior to the conclusion of any disciplinary action proceeding for conduct that might constitute grounds for disciplinary action under this chapter, or prior to the commencement of formal charges but after the applicant or licensee had knowledge that formal charges were contemplated or in preparation.

Subd. 3. **Professional societies or associations.** A state or local professional society or association for licensees shall forward to the board any complaint received concerning the ethics or conduct of the practice which the board regulates. The society or association shall forward a complaint to the board upon receipt of the complaint. The society or association shall also report to the board any disciplinary action taken against a member.

Subd. 4. **Licensed professionals.** (a) A licensed health professional shall report to the board information on the following conduct by an applicant or a licensee:

(1) sexual contact or sexual conduct with a client or a former client;

(2) failure to make reports required by section 626.556 or 626.557;

(3) impairment in the ability to practice by reason of illness, use of alcohol, drugs, or other chemicals, or as a result of any mental or physical condition;

(4) improper or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws;

(5) fraud in the licensure application process or any other false statements made to the board;

(6) conviction of a felony reasonably related to the practice of social work, including conviction of the psychotherapist sex crimes in chapter 609; and

(7) a violation of a board order.

(b) A licensed health professional shall also report to the board information on any other conduct by an applicant or a licensee that constitutes grounds for disciplinary action under this chapter or the rules of the board when the licensed health professional reasonably believes, after appropriate assessment, that the client's functioning has been or likely will be affected negatively by the conduct, regardless of whether the conduct has ceased.

(c) Notwithstanding paragraphs (a) and (b), a licensed health professional shall report to the board knowledge of any actions which institutions must report under subdivision 2.

Subd. 5. **Reporting other licensed professionals.** An applicant or a licensee shall report to the appropriate board conduct by a licensed health professional which would constitute grounds for disciplinary action under the chapter governing the practice of the other licensed health professional and which is required by law to be reported to the same board.

Subd. 6. **Insurers and other entities making liability payments.** (a) Four times each year as prescribed by the board, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to licensees, or the Medical Joint Underwriting Association under chapter 62F, shall submit to the board a report concerning the licensees against whom malpractice settlements or awards have been made to the plaintiff. The report must contain at least the following information:

(1) the total number of malpractice settlements or awards made;

(2) the date the malpractice settlements or awards were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the licensee against whom an award was made or with whom a settlement was made; and

(6) the name of the licensee against whom an award was made or with whom a settlement was made.

(b) A medical clinic, hospital, political subdivision, or other entity which makes professional liability insurance payments on behalf of applicants or licensees shall submit to the board a report concerning malpractice settlements or awards paid on behalf of applicants or licensees, and any settlements

or awards paid by a clinic, hospital, political subdivision, or other entity on its own behalf because of care rendered by applicants or licensees. This requirement excludes forgiveness of bills. The report shall be made to the board within 30 days of payment of all or part of any settlement or award.

(c) The insurance company or other entity making professional liability insurance payments shall, in addition to the information in paragraph (b), report to the board any information it possesses that tends to substantiate a charge, including the factual data underlying a settlement, that an applicant or a licensee may have engaged in conduct violating this chapter.

Subd. 7. **Courts.** The court administrator of district court or any other court of competent jurisdiction shall report to the board any judgment or other determination of the court that adjudges or includes a finding that an applicant or a licensee is a person who is mentally ill, mentally incompetent, guilty of a felony, guilty of a violation of federal or state narcotics laws or controlled substances act, or guilty of an abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the applicant or licensee pursuant to sections 524.5-101 to 524.5-502 or commits an applicant or a licensee pursuant to chapter 253B.

Subd. 8. **Self-reporting.** An applicant or a licensee shall report to the board any personal action that would require that a report be filed by any person, health care facility, business, or organization pursuant to subdivisions 2 to 7.

Subd. 9. **Deadlines; forms.** Reports required by subdivisions 2 to 8 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

Subd. 10. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 8 or any related documents.

148B.284 IMMUNITY.

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting in good faith a report under section 148B.283 or for otherwise reporting, providing information, or testifying about violations or alleged violations of this chapter. The reports are classified under section 13.41.

Subd. 2. **Investigation.** Board members and employees; persons engaged on behalf of the board in the investigation of violations and in the preparation, presentation, and management of and testimony pertaining to charges of violations; and persons engaged in monitoring compliance with statutes, rules, board orders, or corrective action agreements are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

148B.285 DISCLOSURE.

Subdivision 1. **Contested case proceedings.** (a) Upon application of a party in a board hearing or a contested case hearing before the board, the board shall produce and permit the inspection and copying, by or on behalf of the moving party, of

any designated documents or papers relevant to the proceedings, in accordance with rule 34, Minnesota Rules of Civil Procedure.

(b) The board hearing or contested case hearing shall be open to the public, except that the board or administrative law judge shall close the hearing for testimony by clients, and testimony and argument about clients.

(c) Notwithstanding section 13.41, information which may identify a client, client records, and licensee health records are private data during the contested case hearing, as part of the hearing record, and as part of any appellate or other court record.

(d) Clients may waive the protections afforded by this subdivision.

Subd. 2. **Information on disciplinary actions.** If the board imposes disciplinary measures or takes disciplinary action of any kind, the name and business address of the licensee, the nature of the misconduct, and the action taken by the board, including all settlement agreements and other board orders, are public data.

Subd. 3. **Exchange of information.** The board shall exchange information with other boards, agencies, or departments within the state, as required under section 214.10, subdivision 8, paragraph (c).

Subd. 4. **Information to the complainant.** The board shall furnish to a person who made a complaint a statement of the result of an investigation of the complaint and a description of the activities and actions of the board relating to the complaint.

Subd. 5. **Classification of certain residence addresses and telephone numbers.** Notwithstanding section 13.41, subdivision 2 or 4, the residence address and telephone number of an applicant or licensee are private data on individuals as defined in section 13.02, subdivision 12, if the applicant or licensee so requests and provides an alternative address and telephone number.

Subd. 6. **Publication of disciplinary actions.** At least annually, each board shall publish and release to the public a description of all disciplinary measures or actions taken by the board. The publication must include, for each disciplinary measure or action taken, the name and business address of the licensee, the nature of the misconduct, and the measure or action taken by the board.

148B.286 PROFESSIONAL ACCOUNTABILITY.

Subdivision 1. **Investigation.** The board shall maintain and keep current a file containing the reports and complaints filed against applicants or licensees within the board's jurisdiction. Each complaint filed with the board pursuant to chapter 214 must be investigated according to chapter 214. If the files maintained by the board show that a malpractice settlement or award to the plaintiff has been made against an applicant or a licensee as reported by insurers under section 148B.283, the executive director of the board shall notify the board and the board may authorize a review of the provider's practice.

Subd. 2. **Attorney general investigates.** When the board initiates a review of an applicant's or a licensee's practice it shall notify the attorney general who shall investigate the matter in the same manner as provided in chapter 214. If an investigation is to be made, the attorney general

shall notify the applicant or licensee, and, if the incident being investigated occurred there, the administrator and chief of staff at the health care facilities or clinics in which the professional serves, if applicable.

Subd. 3. **Access to records.** The board shall be allowed access to any records of a client provided services by the applicant or licensee under review. If the client has not signed a consent permitting access, the applicant, licensee, or custodian of the records shall first delete the client's name or other client identifiers before providing the records to the board.

148B.287 MALPRACTICE HISTORY.

Subdivision 1. **Submission.** Licensees or applicants for licensure who have previously practiced in another state shall submit with their application the following information:

(1) number, date, and disposition of any malpractice settlement or award made relating to the quality of services provided by the licensee or applicant; and

(2) number, date, and disposition of any civil litigations or arbitrations relating to the quality of services provided by the licensee or applicant in which the party complaining against the licensee or applicant prevailed or otherwise received a favorable decision or order.

Subd. 2. **Board action.** The board shall give due consideration to the information submitted under this section. A licensee or applicant for licensure who willfully submits incorrect information is subject to disciplinary action under this chapter.

148B.288 EVIDENCE OF PAST SEXUAL CONDUCT.

In a proceeding for the suspension or revocation of the right to practice or other disciplinary or adverse action involving sexual contact with a client or former client, the board or administrative law judge shall not consider evidence of the client's previous sexual conduct nor shall any reference to this conduct be made during the proceedings or in the findings, except by motion of the complainant, unless the evidence would be admissible under the applicable provisions of section 609.347, subdivision 3.

148B.289 TAX CLEARANCE CERTIFICATE.

Subdivision 1. **Certificate required.** The board may not issue or renew a license if the commissioner of revenue notifies the board and the licensee or applicant for a license that the licensee or applicant owes the state delinquent taxes in the amount of $500 or more. The board may issue or renew a license or filing only if the commissioner of revenue issues a tax clearance certificate and the commissioner of revenue or the licensee or applicant forwards a copy of the clearance to the board. The commissioner of revenue may issue a clearance certificate only if the licensee or applicant does not owe the state any uncontested delinquent taxes. For purposes of this section, "taxes" means all taxes payable to the commissioner of revenue, including penalties and interest due on those taxes. "Delinquent taxes" do not include a tax liability if (1) an administrative or court action that contests the amount or validity of the liability has been filed or served, (2) the appeal period to contest the tax liability has not expired, or (3) the licensee or applicant has entered into a payment agreement to pay the liability and is current with the payments.

Subd. 2. **Hearing.** In lieu of the notice and hearing

requirements of section 148B.281, when a licensee or applicant is required to obtain a clearance certificate under this subdivision, a contested case hearing must be held if the licensee or applicant requests a hearing in writing to the commissioner of revenue within 30 days of the date of the notice required in subdivision 1. The hearing must be held within 45 days of the date the commissioner of revenue refers the case to the Office of Administrative Hearings. Notwithstanding any other law, the licensee or applicant must be served with 20 days' notice in writing specifying the time and place of the hearing and the allegations against the licensee or applicant. The notice may be served personally or by mail.

Subd. 3. **Information required.** The board shall require all licensees or applicants to provide their Social Security number and Minnesota business identification number on all license applications. Upon request of the commissioner of revenue, the board must provide to the commissioner of revenue a list of all licensees and applicants, including the name and address, Social Security number, and business identification number. The commissioner of revenue may request a list of the licensees and applicants no more than once each calendar year.

148B.60 DEFINITIONS.

Subdivision 1. **Terms.** As used in sections 148B.60 to 148B.71, the following terms have the meanings given them in this section.

Subd. 2. **Office of Mental Health Practice or office.** "Office of Mental Health Practice" or "office" means the Office of Mental Health Practice established in section 148B.61.

Subd. 3. **Unlicensed mental health practitioner or practitioner.** "Unlicensed mental health practitioner" or "practitioner" means a person who provides or purports to provide, for remuneration, mental health services as defined in subdivision 4. It does not include persons licensed by the Board of Medical Practice under chapter 147 or registered by the Board of Medical Practice under chapter 147A; the Board of Nursing under sections 148.171 to 148.285; the Board of Psychology under sections 148.88 to 148.98; the Board of Social Work under sections 148B.18 to 148B.289; the Board of Marriage and Family Therapy under sections 148B.29 to 148B.39; the Board of Behavioral Health and Therapy under sections 148B.50 to 148B.593; or another licensing board if the person is practicing within the scope of the license; members of the clergy who are providing pastoral services in the context of performing and fulfilling the salaried duties and obligations required of a member of the clergy by a religious congregation; American Indian medicine men and women; licensed attorneys; probation officers; school counselors employed by a school district while acting within the scope of employment as school counselors; registered occupational therapists; or occupational therapy assistants. For the purposes of complaint investigation or disciplinary action relating to an individual practitioner, the term includes:

(1) persons employed by a program licensed by the commissioner of human services who are acting as mental health practitioners within the scope of their employment;

(2) persons employed by a program licensed by the commissioner of human services who are providing chemical dependency counseling services; persons who are providing chemical dependency counseling services in private practice; and

(3) clergy who are providing mental health services that are equivalent to those defined in subdivision 4.

Subd. 4. **Mental health services.** "Mental health services" means psychotherapy and the professional assessment, treatment, or counseling of another person for a cognitive, behavioral, emotional, social, or mental condition, symptom, or dysfunction, including intrapersonal or interpersonal dysfunctions. The term does not include pastoral services provided by members of the clergy to members of a religious congregation in the context of performing and fulfilling the salaried duties and obligations required of a member of the clergy by that religious congregation.

Subd. 5. **Mental health client or client.** "Mental health client" or "client" means a person who receives or pays for the services of a mental health practitioner.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 8. **Disciplinary action.** "Disciplinary action" means an adverse action taken by the commissioner against an unlicensed mental health practitioner relating to the person's right to provide mental health services.

148B.61 OFFICE OF MENTAL HEALTH PRACTICE.

Subdivision 1. **Creation.** The Office of Mental Health Practice is created in the Department of Health to investigate complaints and take and enforce disciplinary actions against all unlicensed mental health practitioners for violations of prohibited conduct, as defined in section 148B.68. The office shall also serve as a clearinghouse on mental health services and both licensed and unlicensed mental health professionals, through the dissemination of objective information to consumers and through the development and performance of public education activities, including outreach, regarding the provision of mental health services and both licensed and unlicensed mental health professionals who provide these services.

Subd. 2. **Rulemaking.** The commissioner of health shall adopt rules necessary to implement, administer, or enforce provisions of sections 148B.60 to 148B.71 pursuant to chapter 14. The commissioner may not adopt rules that restrict or prohibit persons from providing mental health services on the basis of education, training, experience, or supervision.

148B.63 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for disciplinary action relating to unlicensed practice under this chapter may report the violation to the Office of Mental Health Practice.

Subd. 2. **Institutions.** A state agency, political subdivision, agency of a local unit of government, private agency, hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the Office of Mental Health Practice any action taken by the agency, institution, or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition an unlicensed mental health practitioner's privilege to practice or treat patients or clients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action for conduct that might constitute grounds for disciplinary action by the office under this chapter. The institution, organization,

or governmental entity shall also report the resignation of any unlicensed mental health practitioners prior to the conclusion of any disciplinary action proceeding for conduct that might constitute grounds for disciplinary action under this chapter, or prior to the commencement of formal charges but after the practitioner had knowledge that formal charges were contemplated or were being prepared.

Subd. 3. **Professional societies.** A state or local professional society for unlicensed mental health practitioners shall report to the Office of Mental Health Practice any termination, revocation, or suspension of membership or any other disciplinary action taken against an unlicensed practitioner. If the society has received a complaint that might be grounds for discipline under this chapter against a member on which it has not taken any disciplinary action, the society shall report the complaint and the reason why it has not taken action on it or shall direct the complainant to the Office of Mental Health Practice.

Subd. 4. **Licensed professionals.** A licensed health professional shall report to the Office of Mental Health Practice personal knowledge of any conduct that the licensed health professional reasonably believes constitutes grounds for disciplinary action under this chapter by any unlicensed mental health practitioner, including conduct indicating that the individual may be medically incompetent, or may be medically or physically unable to engage safely in the provision of services. If the information was obtained in the course of a client relationship, the client is an unlicensed mental health practitioner, and the treating individual successfully counsels the other practitioner to limit or withdraw from practice to the extent required by the impairment, the office may deem this limitation of or withdrawal from practice to be sufficient disciplinary action.

Subd. 5. **Insurers.** Four times each year as prescribed by the commissioner, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to unlicensed mental health practitioners or the Medical Joint Underwriting Association under chapter 62F, shall submit to the Office of Mental Health Practice a report concerning the unlicensed mental health practitioners against whom malpractice settlements or awards have been made. The response must contain at least the following information:

(1) the total number of malpractice settlements or awards made;

(2) the date the malpractice settlements or awards were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the unlicensed practitioner against whom an award was made or with whom a settlement was made; and

(6) the name of the unlicensed practitioner against whom an award was made or with whom a settlement was made.

The insurance company shall, in addition to the above information, submit to the Office of Mental Health Practice any information, records, and files, including clients' charts and

records, it possesses that tend to substantiate a charge that an unlicensed mental health practitioner may have engaged in conduct violating this chapter.

Subd. 6. **Courts.** The court administrator of district court or any other court of competent jurisdiction shall report to the Office of Mental Health Practice any judgment or other determination of the court that adjudges or includes a finding that an unlicensed mental health practitioner is mentally ill, mentally incompetent, guilty of a felony, guilty of a violation of federal or state narcotics laws or controlled substances act, or guilty of abuse or fraud under Medicare or Medicaid; or that appoints a guardian of the unlicensed mental health practitioner under sections 524.5-101 to 524.5-502 or commits an unlicensed mental practitioner under chapter 253B.

Subd. 7. **Self-reporting.** An unlicensed mental health practitioner shall report to the Office of Mental Health Practice any personal action that would require that a report be filed with the office by any person, health care facility, business, or organization pursuant to subdivisions 2 to 5. The practitioner shall also report the revocation, suspension, restriction, limitation, or other disciplinary action against the mental health practitioner's license, certificate, registration, or right of practice in another state or jurisdiction, for offenses that would be subject to disciplinary action in this state and also report the filing of charges regarding the practitioner's license, certificate, registration, or right of practice in another state or jurisdiction.

Subd. 8. **Deadlines; forms.** Reports required by subdivisions 2 to 7 must be submitted not later than 30 days after the reporter learns of the occurrence of the reportable event or transaction. The Office of Mental Health Practice may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to assure prompt and accurate reporting.

148B.64 IMMUNITY.

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the Office of Mental Health Practice, for otherwise reporting to the office violations or alleged violations of this chapter, or for cooperating with an investigation of a report, except as provided in this subdivision. Any person who knowingly or recklessly makes a false report is liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury. An action requires clear and convincing evidence that the defendant made the statement with knowledge of falsity or with reckless disregard for its truth or falsity. The report or statement or any statement made in cooperation with an investigation or as part of a disciplinary proceeding is privileged except in an action brought under this subdivision.

Subd. 2. **Investigation.** The commissioner and employees of the Department of Health and other persons engaged in the investigation of violations and in the preparation, presentation, and management of and testimony pertaining to charges of violations of this chapter are absolutely immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating

to, their duties under this chapter.

148B.65 DISCIPLINARY RECORD ON JUDICIAL REVIEW.

Upon judicial review of any disciplinary action taken by the commissioner under this chapter, the reviewing court shall seal the administrative record, except for the commissioner's final decision, and shall not make the administrative record available to the public.

148B.66 PROFESSIONAL COOPERATION; UNLICENSED PRACTITIONER.

Subdivision 1. **Cooperation.** An unlicensed mental health practitioner who is the subject of an investigation, or who is questioned in connection with an investigation, by or on behalf of the Office of Mental Health Practice shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the office relating to the subject of the investigation, whether tape recorded or not, and providing copies of client records, as reasonably requested by the office, to assist the office in its investigation, and appearing at conferences or hearings scheduled by the commissioner. If the office does not have a written consent from a client permitting access to the client's records, the unlicensed mental health practitioner shall delete any data in the record that identifies the client before providing it to the office. The office shall maintain any records obtained pursuant to this section as investigative data pursuant to section 13.41. If an unlicensed mental health practitioner refuses to give testimony or produce any documents, books, records, or correspondence on the basis of the fifth amendment to the Constitution of the United States, the commissioner may compel the unlicensed mental health practitioner to provide the testimony or information; however, the testimony or evidence may not be used against the practitioner in any criminal proceeding. Challenges to requests of the office may be brought before the appropriate agency or court.

Subd. 2. **Classification of data.** The commissioner shall maintain any records, other than client records, obtained as part of an investigation, as investigative data under section 13.41. Client records are classified as private under chapter 13 and must be protected as such in the records of the office and in any administrative or judicial proceeding unless the client authorizes the office in writing to make public the identity of the client or a portion or all of the client's records.

Subd. 3. **Exchanging information.** (a) The Office of Mental Health Practice shall establish internal operating procedures for:

(1) exchanging information with state boards; agencies, including the Office of Ombudsman for Mental Health and Mental Retardation; health related and law enforcement facilities; departments responsible for licensing health related occupations, facilities, and programs; and law enforcement personnel in this and other states; and

(2) coordinating investigations involving matters within the jurisdiction of more than one regulatory agency.

(b) The procedures for exchanging information must provide for the forwarding to the entities described in paragraph (a), clause (1), of information and evidence, including the results of investigations, that are relevant to matters within the

regulatory jurisdiction of the organizations in paragraph (a). The data have the same classification in the hands of the agency receiving the data as they have in the hands of the agency providing the data.

(c) The Office of Mental Health Practice shall establish procedures for exchanging information with other states regarding disciplinary action against licensed and unlicensed mental health practitioners.

(d) The Office of Mental Health Practice shall forward to another governmental agency any complaints received by the office that do not relate to the office's jurisdiction but that relate to matters within the jurisdiction of the other governmental agency. The agency to which a complaint is forwarded shall advise the Office of Mental Health Practice of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule that the Office of Mental Health Practice is empowered to enforce must be forwarded to the office to be processed in accordance with this section.

(e) The Office of Mental Health Practice shall furnish to a person who made a complaint a description of the actions of the office relating to the complaint.

148B.67 PROFESSIONAL ACCOUNTABILITY.

The Office of Mental Health Practice shall maintain and keep current a file containing the reports and complaints filed against unlicensed mental health practitioners within the commissioner's jurisdiction. Each complaint filed with the office must be investigated. If the files maintained by the office show that a malpractice settlement or award has been made against an unlicensed mental health practitioner, as reported by insurers under section 148B.63, subdivision 5, the commissioner may authorize a review of the practitioner's practice by the staff of the Office of Mental Health Practice.

148B.68 PROHIBITED CONDUCT.

Subdivision 1. **Prohibited conduct.** The commissioner may impose disciplinary action as described in section 148B.69 against any unlicensed mental health practitioner. The following conduct is prohibited and is grounds for disciplinary action:

(a) Conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court in Minnesota or any other jurisdiction in the United States, reasonably related to the provision of mental health services. Conviction, as used in this subdivision, includes a conviction of an offense which, if committed in this state, would be deemed a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered.

(b) Conviction of crimes against persons. For purposes of this chapter, a crime against a person means violations of the following: sections 609.185; 609.19; 609.195; 609.20; 609.205; 609.21; 609.215; 609.221; 609.222; 609.223; 609.224; 609.2242; 609.23; 609.231; 609.2325; 609.233; 609.2335; 609.235; 609.24; 609.245; 609.25; 609.255; 609.26, subdivision 1, clause (1) or (2); 609.265; 609.342; 609.343; 609.344; 609.345; 609.365; 609.498, subdivision 1; 609.50, clause (1); 609.561; 609.562; 609.595; and 609.72, subdivision 3.

(c) Failure to comply with the self-reporting requirements

of section 148B.63, subdivision 7.

(d) Engaging in sexual contact with a client or former client as defined in section 148A.01, or engaging in contact that may be reasonably interpreted by a client as sexual, or engaging in any verbal behavior that is seductive or sexually demeaning to the patient, or engaging in sexual exploitation of a client or former client.

(e) Advertising that is false, fraudulent, deceptive, or misleading.

(f) Conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a client; or any other practice that may create unnecessary danger to any client's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(g) Adjudication as mentally incompetent, or as a person who is dangerous to self, or adjudication pursuant to chapter 253B, as chemically dependent, mentally ill, mentally retarded, mentally ill and dangerous to the public, or as a sexual psychopathic personality or sexually dangerous person.

(h) Inability to provide mental health services with reasonable safety to clients.

(i) The habitual overindulgence in the use of or the dependence on intoxicating liquors.

(j) Improper or unauthorized personal or other use of any legend drugs as defined in chapter 151, any chemicals as defined in chapter 151, or any controlled substance as defined in chapter 152.

(k) Revealing a communication from, or relating to, a client except when otherwise required or permitted by law.

(l) Failure to comply with a client's request made under section 144.335, or to furnish a client record or report required by law.

(m) Splitting fees or promising to pay a portion of a fee to any other professional other than for services rendered by the other professional to the client.

(n) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(o) Failure to make reports as required by section 148B.63, or cooperate with an investigation of the office.

(p) Obtaining money, property, or services from a client, other than reasonable fees for services provided to the client, through the use of undue influence, harassment, duress, deception, or fraud.

(q) Undertaking or continuing a professional relationship with a client in which the objectivity of the professional would be impaired.

(r) Failure to provide the client with a copy of the client bill of rights or violation of any provision of the client bill of rights.

(s) Violating any order issued by the commissioner.

(t) Failure to comply with sections 148B.60 to 148B.71, and the rules adopted under those sections.

(u) Failure to comply with any additional disciplinary grounds established by the commissioner by rule.

(v) Revocation, suspension, restriction, limitation, or other disciplinary action against the mental health practitioner's license, certificate, registration, or right of

practice in this or another state or jurisdiction, for offenses that would be subject to disciplinary action in this state, or failure to report to the Office of Mental Health Practice that charges regarding the practitioner's license, certificate, registration, or right of practice have been brought in this or another state or jurisdiction.

(w) Bartering for services with a client.

Subd. 2. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, paragraph (a), (b), (c), or (g), a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of its contents.

Subd. 3. **Examination; access to medical data.** (a) If the commissioner has probable cause to believe that an unlicensed mental health practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j), the commissioner may issue an order directing the practitioner to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, every unlicensed mental health practitioner is deemed to have consented to submit to a mental or physical examination or chemical dependency evaluation when ordered to do so in writing by the commissioner of health and further to have waived all objections to the admissibility of the testimony or examination reports of the health care provider performing the examination or evaluation on the grounds that the same constitute a privileged communication. Failure of an unlicensed mental health practitioner to submit to an examination or evaluation when ordered, unless the failure was due to circumstances beyond the practitioner's control, constitutes an admission that the unlicensed mental health practitioner violated subdivision 1, paragraph (g), (h), (i), or (j), based on the factual specifications in the examination or evaluation order and may result in a default and final disciplinary order being entered after a contested case hearing. An unlicensed mental health practitioner affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the practitioner can resume the provision of mental health services with reasonable safety to clients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the commissioner shall be used against a mental health practitioner in any other proceeding.

(b) In addition to ordering a physical or mental examination or chemical dependency evaluation, the commissioner may, notwithstanding section 13.384, 144.651, 595.02, or any other law limiting access to medical or other health data, obtain medical data and health records relating to an unlicensed mental health practitioner without the practitioner's consent if the commissioner has probable cause to believe that a practitioner has engaged in conduct prohibited by subdivision 1, paragraph (g), (h), (i), or (j). The medical data may be requested from a health care professional, as defined in section 144.335, subdivision 1, paragraph (b), an insurance company, or a government agency, including the Department of Human Services. A health care professional, insurance company, or government agency shall comply with any written request of the commissioner under this subdivision and is not liable in any action for damages for releasing the data requested by the

commissioner if the data are released pursuant to a written request under this subdivision, unless the information is false and the person or organization giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is private data under section 13.41.

148B.69 DISCIPLINARY ACTIONS.

Subdivision 1. **Forms of disciplinary action.** When the commissioner finds that an unlicensed mental health practitioner has violated a provision or provisions of this chapter, the commissioner may take one or more of the following actions, only against the individual practitioner:

(1) revoke the right to practice;

(2) suspend the right to practice;

(3) impose limitations or conditions on the practitioner's provision of mental health services, the imposition of rehabilitation requirements, or the requirement of practice under supervision;

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the practitioner of any economic advantage gained by reason of the violation charged or to reimburse the Office of Mental Health Practice for all costs of the investigation and proceeding;

(5) order the practitioner to provide unremunerated professional service under supervision at a designated public hospital, clinic, or other health care institution;

(6) censure or reprimand the practitioner;

(7) impose a fee on the practitioner to reimburse the office for all or part of the cost of the proceedings resulting in disciplinary action including, but not limited to, the amount paid by the office for services from the Office of Administrative Hearings, attorney fees, court reports, witnesses, reproduction of records, staff time, and expense incurred by the staff of the Office of Mental Health Practice; or

(8) any other action justified by the case.

Subd. 2. **Discovery; subpoenas.** In all matters relating to the lawful activities of the Office of Mental Health Practice, the commissioner of health may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which the person may be lawfully questioned or failing to produce any papers, books, records, documents, or other evidentiary materials in the matter to be heard, after having been required by order of the commissioner or by a subpoena of the commissioner to do so may, upon application to the district court in any district, be ordered to comply with the order or subpoena. The commissioner of health may administer oaths to witnesses or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a person it names anywhere within the state by any officer authorized to serve subpoenas or other process or paper in civil actions, in the same manner as prescribed by law for service of process issued out of the district court of this state.

Subd. 2a. **Hearings.** If the commissioner proposes to take action against the practitioner as described in subdivision 1, the commissioner must first notify the person against whom the action is proposed to be taken and provide the person with an opportunity to request a hearing under the contested case provisions of chapter 14. If the person does not request a hearing by notifying the commissioner within 30 days after service of the notice of the proposed action, the commissioner may proceed with the action without a hearing.

Subd. 3. **Reinstatement.** The commissioner may at the commissioner's discretion reinstate the right to practice and may impose any disciplinary measure listed under subdivision 1.

Subd. 4. **Temporary suspension.** In addition to any other remedy provided by law, the commissioner may, acting through a person to whom the commissioner has delegated this authority and without a hearing, temporarily suspend the right of an unlicensed mental health practitioner to practice if the commissioner's delegate finds that the practitioner has violated a statute or rule that the commissioner is empowered to enforce and continued practice by the practitioner would create a serious risk of harm to others. The suspension is in effect upon service of a written order on the practitioner specifying the statute or rule violated. The order remains in effect until the commissioner issues a final order in the matter after a hearing or upon agreement between the commissioner and the practitioner. Service of the order is effective if the order is served on the practitioner or counsel of record personally or by first class mail. Within ten days of service of the order, the commissioner shall hold a hearing on the sole issue of whether there is a reasonable basis to continue, modify, or lift the suspension. Evidence presented by the office or practitioner shall be in affidavit form only. The practitioner or the counsel of record may appear for oral argument. Within five working days after the hearing, the commissioner shall issue the commissioner's order and, if the suspension is continued, schedule a contested case hearing within 45 days after issuance of the order. The administrative law judge shall issue a report within 30 days after closing of the contested case hearing record. The commissioner shall issue a final order within 30 days after receipt of that report.

Subd. 5. **Automatic suspension.** The right to practice is automatically suspended if (1) a guardian of an unlicensed mental health practitioner is appointed by order of a court under sections 524.5-101 to 524.5-502, or (2) the practitioner is committed by order of a court pursuant to chapter 253B. The right to practice remains suspended until the practitioner is restored to capacity by a court and, upon petition by the practitioner, the suspension is terminated by the commissioner after a hearing or upon agreement between the commissioner and the practitioner.

Subd. 6. **Public employees.** Notwithstanding subdivision 1, the commissioner must not take disciplinary action against an employee of the state or a political subdivision of the state. If, after an investigation conducted in compliance with and with the authority granted under sections 148B.60 to 148B.71, the commissioner determines that the employee violated a provision or provisions of this chapter, the commissioner shall report to the employee's employer the commissioner's findings and the actions the commissioner

recommends that the employer take. The commissioner's recommendations are not binding on the employer.

Subd. 7. **Release to obtain nonpublic data.** An unlicensed mental health practitioner who is the subject of an investigation must sign a release authorizing the commissioner to obtain criminal conviction data, reports about abuse or neglect of clients, and other information pertaining to investigations of violations of statutes or rules from the Bureau of Criminal Apprehension, the Federal Bureau of Investigation, the Department of Human Services, the Office of Health Facilities Complaints, private certification organizations, county social service agencies, the Division of Driver and Vehicle Services in the Department of Public Safety, adult protection services, child protection services, and other agencies that regulate provision of health care services. After the commissioner gives written notice to an individual who is the subject of an investigation, the agencies shall assist the commissioner with the investigation by giving the commissioner the requested data.

148B.70 ADDITIONAL REMEDIES.

Subdivision 1. **Cease and desist.** The commissioner of health may issue a cease and desist order to stop a person from violating or threatening to violate a statute, rule, or order which the Office of Mental Health Practice has issued or is empowered to enforce. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under sections 14.57 to 14.62. If, within 15 days of service of the order, the subject of the order fails to request a hearing in writing, the order is the final order of the commissioner and is not reviewable by a court or agency.

A hearing must be initiated by the Office of Mental Health Practice not later than 30 days from the date of the office's receipt of a written hearing request. Within 30 days of receipt of the administrative law judge's report, the commissioner shall issue a final order modifying, vacating, or making permanent the cease and desist order as the facts require. The final order remains in effect until modified or vacated by the commissioner.

When a request for a stay accompanies a timely hearing request, the commissioner may, in the commissioner's discretion, grant the stay. If the commissioner does not grant a requested stay, the commissioner shall refer the request to the Office of Administrative Hearings within three working days of receipt of the request. Within ten days after receiving the request from the commissioner, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receiving the administrative law judge's recommendation.

In the event of noncompliance with a cease and desist order, the commissioner may institute a proceeding in Hennepin County District Court to obtain injunctive relief or other appropriate relief, including a civil penalty payable to the Office of Mental Health Practice not exceeding $10,000 for each separate violation.

Subd. 2. **Injunctive relief.** In addition to any other remedy provided by law, including the issuance of a cease and desist order under subdivision 1, the commissioner may in the commissioner's own name bring an action in Hennepin County District Court for injunctive relief to restrain an unlicensed mental health practitioner from a violation or threatened

violation of any statute, rule, or order which the commissioner is empowered to regulate, enforce, or issue. A temporary restraining order must be granted in the proceeding if continued activity by a practitioner would create a serious risk of harm to others. The commissioner need not show irreparable harm.

Subd. 3. **Additional powers.** The issuance of a cease and desist order or injunctive relief granted under this section does not relieve a practitioner from criminal prosecution by a competent authority or from disciplinary action by the commissioner.

148B.71 MENTAL HEALTH CLIENT BILL OF RIGHTS.

Subdivision 1. **Scope.** All unlicensed mental health practitioners, other than those providing services in a facility or program licensed by the commissioner of health or the commissioner of human services, shall provide to each client prior to providing treatment a written copy of the mental health client bill of rights. A copy must also be posted in a prominent location in the office of the mental health practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English. The mental health client bill of rights shall include the following:

(a) the name, title, business address, and telephone number of the practitioner;

(b) the degrees, training, experience, or other qualifications of the practitioner, followed by the following statement in bold print:

"THE STATE OF MINNESOTA HAS NOT ADOPTED UNIFORM EDUCATIONAL AND TRAINING STANDARDS FOR ALL MENTAL HEALTH PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY."

(c) the name, business address, and telephone number of the practitioner's supervisor, if any;

(d) notice that a client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints;

(e) the name, address, and telephone number of the Office of Mental Health Practice and notice that a client may file complaints with the office;

(f) 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;

(g) a statement that the client has a right to reasonable notice of changes in services or charges;

(h) a brief summary, in plain language, of the theoretical approach used by the practitioner in treating patients;

(i) notice that the client has a right to complete and current information concerning the practitioner's assessment and recommended course of treatment, including the expected duration of treatment;

(j) a statement that clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner;

(k) 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;

(l) a statement of the client's right to be allowed access to records and written information from records in accordance with section 144.335;

(m) a statement that other services may be available in the community, including where information concerning services is available;

(n) 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;

(o) a statement that the client has a right to coordinated transfer when there will be a change in the provider of services;

(p) a statement that the client may refuse services or treatment, unless otherwise provided by law; and

(q) a statement that the client may assert the client's rights without retaliation.

Subd. 2. **Acknowledgment by client.** Prior to the provision of any service, the client must sign a written statement attesting that the client has received the client bill of rights.

148C.01 DEFINITIONS.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of health, or a designee.

148C.02 ALCOHOL AND DRUG COUNSELORS LICENSING ADVISORY COUNCIL.

Subdivision 1. **Membership.** The Alcohol and Drug Counselors Licensing Advisory Council consists of 13 members. The commissioner shall appoint:

(1) except for those members initially appointed, seven members who must be licensed alcohol and drug counselors;

(2) three members who must be public members as defined by section 214.02;

(3) one member who must be a director or coordinator of an accredited alcohol and drug dependency training program; and

(4) one member who must be a former consumer of alcohol and drug dependency counseling service and who must have received the service more than three years before the person's appointment.

The American Indian Advisory Committee to the Department of Human Services Chemical Dependency Office shall appoint the remaining member.

Subd. 2. **Duties.** The advisory council shall:

(1) provide advice and recommendations to the commissioner on the development of rules for the licensure of alcohol and drug counselors;

(2) provide advice and recommendations to the commissioner on the development of standards and procedures for the competency testing, licensing, and review of alcohol and drug counselors' professional conduct;

(3) provide advice and recommendations to the commissioner in disciplinary cases in the areas of counselor competency issues, counselor practice issues, and counselor impairment issues.

Subd. 3. **Terms.** The terms, compensation, and removal of members shall be as provided in section 15.059, except that

notwithstanding any contrary law, the advisory council shall not expire.

148C.12 FEES.

Subd. 4. **Examination fee.** The examination fee for the written examination is $95 and for the oral examination is $200.

153A.14 REGULATION.

Subd. 2a. **Exemption from written examination requirement.** Persons completing the audiology registration requirements of section 148.515 after January 1, 1996, are exempt from the written examination requirements of subdivision 2h, paragraph (a), clause (1). Minnesota licensure, a current certification of clinical competence issued by the American Speech-Language-Hearing Association, board certification in audiology by the American Board of Audiology, or an equivalent, as an audiologist is not required but may be submitted as evidence qualifying for exemption from the written examination if the requirements are completed after January 1, 1996. Persons qualifying for written examination exemption must fulfill the other credentialing requirements under subdivisions 1 and 2 before a certificate may be issued by the commissioner.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 1204 - Health-Related Occupations – Licensing (First Engrossment)

Author: Senator Sheila M. Kiscaden

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 19, 2005

Article 1
Board of Social Work

Section 1 (13.383, subdivision 10) makes a conforming change.

Section 2 (13.411, subdivision 5) makes a conforming change.

Section 3 (144.335, subdivision 1) makes a conforming change.

Section 4 (144A.46, subdivision 2) makes a conforming change.

Section 5 (147.09) makes a conforming change.

Section 6 (148D.001) is the citation.

Section 7 (148D.010) defines terms used in the chapter.

Section 8 (148D.015) establishes the scope of the board's regulatory authority.

Section 9 (148D.020) states that Minnesota Statutes, chapter 214, the statute generally governing all licensing boards, applies to the Board of Social Work unless superseded by this new chapter.

Section 10 (148D.025) establishes the board, prescribes membership and membership qualifications, requires an annual election of officers, requires bylaws to be adopted, and requires the appointment of an executive director.

Section 11 (148D.030) outlines board duties.

Section 12 (148D.035) authorizes the board to grant variances from requirements of this chapter, excluding core licensing standards, under certain conditions, if the variance is consistent with protection of public health, safety, and welfare.

Section 13 (148D.040) grants immunity to board members, employees, and agents during the lawful conduct of their duties under this chapter.

Section 14 (148D.045) grants applicants and licensees who are subject to a disciplinary or adversarial action by the board the right to a contested case hearing.

Section 15 (148D.050) outlines the scope of practice for the following licensed practitioners: social workers, graduate social workers, independent social workers, and independent clinical social workers.

Section 16 (148D.055) requires persons who practice or teach social work to be licensed, unless exempted later in this chapter. Qualifications for licensure by examination are outlined for various levels of practice. This section establishes criteria for determining the sufficiency of education obtained outside of the United States or Canada. It establishes a procedure for licensure by endorsement for persons currently licensed or credentialed in another jurisdiction. It establishes board policy with respect to background checks, licensure effective dates and expiration dates, and changes between levels of licensure.

Section 17 (148D.060) authorizes temporary licensure.

Section 18 (148D.065) provides exemptions from licensure.

Section 19 (148D.070) establishes licensure renewal procedures.

Section 20 (148D.075) authorizes inactive licensure when the licensee is granted a temporary leave from active practice or is granted an emeritus license.

Section 21 (148D.080) establishes procedures for reactivating a license that is in temporary leave status or emeritus status, or has expired or been voluntarily terminated.

Section 22 (148D.085) establishes policy governing voluntary license termination.

Section 23 (148D.090) governs reporting of licensee names, addresses, and telephone numbers. A licensee may use the person's legal name or a professional name.

Section 24 (148D.095) governs issuance of license wall certificates and license cards.

Section 25 (148D.100) establishes supervision requirements for licensed social workers.

Section 26 (148D.105) establishes supervision requirements for licensed graduate social workers.

Section 27 (148D.110) establishes supervision requirements for licensed independent social workers.

Section 28 (148D.115) establishes supervision requirements for licensed independent clinical social workers.

Section 29 (148D.120) establishes requirements for persons serving as supervisors and allows for alternative supervisors under certain circumstances.

Section 30 (148D.125) establishes procedures for documenting and verifying the completion of required supervision.

Section 31 (148D.135) requires 30 hours of continuing education every 24 months.

Section 32 (148D.135) establishes criteria for approving continuing education hours.

Section 33 (148D.140) allows the board to grant temporary variances of continuing education requirements under certain circumstances.

Section 34 (148D.145) establishes criteria for board approval of continuing education providers.

Section 35 (148D.150) establishes criteria for continuing education providers approved by an entity other than the board.

Section 36 (148D.155) establishes criteria for continuing education programs approved by the National Association of Social Workers.

Section 37 (148D.160) establishes criteria for board approval of continuing education programs.

Section 38 (148D.165) requires licensees to maintain documentation of continuing education hours earned and authorizes the board to audit applications to determine compliance with continuing education requirements.

Section 39 (148D.170) authorizes the board to revoke the approval of a continuing education program or provider for failure to meet statutory requirements.

Section 40 (148D.175) provides that board fees are nonrefundable and must be deposited in the state government special revenue fund.

Section 41 (148D.180) sets board fee amounts, which are unchanged from current law.

Section 42 (148D.185) states the purpose of the board's compliance statutes is to protect the public by ensuring that all licensees meet minimum standards or practice. The board must investigate complaints and take appropriate corrective action when warranted to protect the public.

Section 43 (148D.190) establishes grounds for board action to enforce licensing requirements. Conduct that occurs before licensure and unauthorized practice may warrant board action under certain circumstances.

Section 44 (148D.195) establishes the standard of practice with respect to representations to clients and the public.

Section 45 (148D.200) sets standards for the provision of competent social work services.

Section 46 (148D.205) establishes grounds for board action when a licensee is impaired due to illness, use of chemicals, or as a result of any mental, physical, or psychological condition. Licensees who are unable to practice competently due to an impairment are required to report to the board or to the Health Professionals Services Program.

Section 47 (148D.210) establishes grounds for board action if a licensee engages in unprofessional or unethical conduct or in other proscribed activities.

Section 48 (148D.215) establishes the responsibilities social workers have with respect to clients.

Section 49 (148D.220) requires social workers to act professionally in relationships with clients and former clients and maintain professional boundaries. This section establishes standards for permissible personal and business relationships with clients and former clients.

Section 50 (148D.225) establishes standards for treatment and intervention services.

Section 51 (148D.230) establishes requirements with respect to confidentiality and records.

Section 52 (148D.235) establishes requirements with respect to social worker fees and billing practices.

Section 53 (148D.240) establishes social worker reporting requirements.

Section 54 (148D.245) establishes the board's investigative powers and procedures.

Section 55 (148D.250) requires applicants or licensees who are the subject of a board investigation or are questioned by the board in connection with an investigation to cooperate fully.

Section 56 (148D.255) authorizes the board to take various types of disciplinary actions against applicants and licensees to address complaints alleging a violation of a statute or rule the board is empowered to enforce.

Section 57 (148D.260) outlines the various disciplinary options available to the board.

Section 58 (148D.265) outlines adversarial but nondisciplinary actions the board may take, including automatic suspensions and cease-and-desist orders.

Section 59 (148D.270) outlines voluntary disciplinary actions the board and an applicant or licensee may agree to, including an agreement for corrective action and a stipulation to cease practicing.

Section 60 (148D.275) prohibits the practice of social work or the provision of social work services without a license, unless the person is exempt from licensure under section 148D.065.

Section 61 (148D.280) prohibits use of the title "social worker" by unlicensed persons unless they practice in a setting exempt from licensure under section 148D.065.

Section 62 (148D.285) requires a variety of public and private entities to report to the board disciplinary action against a person for conduct that might constitute grounds for disciplinary action by the board or the resignation of an applicant or licensee prior to the conclusion of this type of disciplinary action.

Section 63 (148D.290) makes it a misdemeanor to violate chapter 148D.

Section 64 (214.01, subdivision 2) makes a conforming change.

Section 65 (245.462, subdivision 18) makes a conforming change.

Section 66 (245.4871, subdivision 27) makes a conforming change.

Section 67 (256B.0625, subdivision 32) makes a conforming change.

Section 68 (256J.08, subdivision 73a) makes a conforming change.

Section 69 (319B.02, subdivision 19) makes a conforming change.

Section 70 (319B.40) makes a conforming change.

Section 71 repeals the boards current statutes and rules.

Section 72 is the effective date of January 1, 2006.

Article 2
Board of Physical Therapy

Section 1 [148.65] subdivision 3, defines "physical therapist assistant."

Section 2 [148.65] subdivision 4, defines "physical therapy aide."

Section 3 [148. 65] subdivision 5, defines "student physical therapist."

Section 4 [148.65] subdivision 6, defines "student physical therapist assistant."

Section 5 [148.65] subdivision 7, defines "supportive personnel."

Section 6 [148.706] authorizes a physical therapist to delegate duties to a physical therapist assistant and assign tasks to the physical therapist aide in accordance with rules. States that physical therapists who instruct student therapists and student assistants are responsible for the functions performed by the students.

Section 7 [148.735] describes cancellation of a license in good standing.

> **Subdivision 1** states that a physical therapist holding an active license may be granted a license cancellation if the board is not investigating the individual or has not begun disciplinary proceedings against the individual. Such a cancellation shall be reported as a cancellation of a license in good standing.
>
> **Subdivision 2** states that license fees are not refundable if a person is permitted license cancellation.
>
> **Subdivision 3** states that if a physical therapist who has been granted a cancellation desires to resume practice, the therapist must obtain a new license by applying for licensure and fulfilling the requirements that are then in existence for obtaining an initial license to practice.

Section 8 [148.736] describes cancellation of credentials under a disciplinary order.

> **Subdivision 1** states that a physical therapist whose right to practice is under suspension, condition, limitation, or restriction may be granted cancellation of credentials by approval of the board. This action shall be reported as cancellation while under discipline.
>
> **Subdivision 2** states that a person is not entitled to a refund of license fees if allowed credential cancellation.
>
> **Subdivision 3** states that if a therapist who has been granted a credential cancellation desires to resume the practice, that therapist must obtain a new credential by applying to the board and fulfilling the requirements that are in existence for obtaining an initial credential to practice.

Section 9 [148.737] states that the board shall not renew, reissue, reinstate, or restore a license that has lapsed on or after January 1, 2006, and has not been renewed within two annual license renewal cycles starting January 1, 2008. A licensee whose license is cancelled for nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements than in existence for an initial license to practice.

Section 10 [148.75] states that the board may discipline a physical therapist for inadequate supervision of a student physical therapist, physical therapist assistant, student physical therapist assistant, or a physical therapy aide; and for practicing under a lapsed or nonrenewal credential.

Section 11 [148.754] paragraph (a), authorizes the board to direct a physical therapist to submit to a mental or physical examination. States that every physical therapist is deemed to have consented to an evaluation when directed by the board in writing. Failure to submit to the examination constitutes an admission of the allegations.

Paragraph (b) states that the records and orders under this section shall not be used in any other proceeding.

Paragraph (c) permits the board to access medical data and health records without the person's consent if it has probable cause to believe the physical therapist comes under section 148.75, paragraph (a). A provider is immune from liability. All data obtained is classified as private data.

Section 12 [148.755] authorizes the board without a hearing to temporarily suspend the license of a physical therapist if the board finds that the therapist has violated a statute or rule the board is empowered to enforce. Provides that the board shall schedule a disciplinary hearing.

Section 13 provides a license exception for an individual who has been issued a physical therapy license between 1980 and 1995 in at lest three other states and at least one foreign country and applies before August 1, 2005.

Section 14 repeals Rules 5601.0100, subparts 3 and 4.

Article 3
Board of Psychology

Section 1 (148.89, subdivision 5) clarifies that the practice of psychology means the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, or procedures for any reason.

Section 2 (148.90, subdivision 1) makes technical and conforming changes to the makeup of the Board of Psychology.

Section 3 (148.907, subdivision 5) establishes the requirements for converting from a licensed psychological practitioner to a licensed psychologist. In order for a licensed psychological practitioner to obtain a license as a licensed psychologist, the licensed psychological practitioner must have:

(1) completed an application provided by the board;

(2) paid a nonrefundable fee of $500;

(3) documented successful completion of two full years or the equivalent of supervised postlicensure employment meeting specified requirements; and

(4) no unresolved disciplinary action or complaints pending, or incomplete disciplinary orders or corrective action agreements.

Section 4 (148.908, subdivision 2) modifies the requirements for licensure as a licensed psychological practitioner. An applicant must:

(1) complete the educational degree requirements by December 31, 2005;

(2) complete the application for admission to the examination and pay the application fee by December 31, 2005;

(3) complete the application for the professional responsibility examination by December 31, 2005;

(4) pass the examination for professional practice in psychology by December 31, 2006;

(5) pass the professional responsibility examination by December 31, 2006;

(6) complete an application for licensure and pay the fee by March 1, 2007; and

(7) have reached the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending.

Section 5 (148.908, subdivision 3) states that effective December 31, 2011, the licensure of all licensed psychological practitioners shall be terminate without further notice and licensure for psychological practitioners shall be eliminated.

Section 6 (148.909) modifies the licensure for volunteer practice by striking language requiring the applicant to be a former licensee and requiring the applicant to have held a license, certificate, or registration for at least 15 years.

Section 7 (148.916, subdivision 2) permits a nonresident who is not seeking licensure to serve as an organizational consultant.

Section 8 (148.925, subdivision 6) makes a technical change.

Section 9 (148.941, subdivision 2) makes a technical change.

Section 10 (148.96, subdivision 3) makes a technical change.

Section 11 is an effective date for **sections 1 to 10** of the day following final enactment.

Article 4
Board of Dental Practice

Section 1 (150A.01, subdivision 6a) makes technical change in the definition of "faculty dentist" clarifying that the facility dentist must be licensed as a faculty dentist.

Section 2 (150A.06, subdivision 1a) permits a limited faculty license to be renewed annually and a full faculty license to be renewed biennially.

Section 3 (150A.091) establishes fees in statute.

Subdivision 1 states that fees are not refundable.

Subdivision 2 establishes an application fee.

Subdivision 3 establishes an initial license or registration fee.

Subdivision 4 establishes an annual license fee.

Subdivision 5 establishes a biennial license or registration fee.

Subdivision 6 establishes an annual license late fee.

Subdivision 7 establishes a biennial license or registration late fee.

Subdivision 8 establishes a duplicate license or registration fee.

Subdivision 9 establishes licensure and registration by credentials fee.

Subdivision 10 establishes reinstatement fees.

Subdivision 11 establishes a certificate application fee for anesthesia/sedation.

Subdivision 12 establishes a duplicate certificate fee for anesthesia/sedation.

Subdivision 13 establishes an on site inspection fee.

Subdivision 14 establishes an affidavit of licensure fee.

Subdivision 15 establishes a verification of licensure fee.

Section 4 (150A.10, subdivision 1a) requires a dental hygienist who is injecting anesthetic agents or administering nitrous oxide under the limited authorization provision must be under either the indirect or general supervision of a licensed dentist. (Currently, the dental hygienist must be under the indirect supervision of a dentist).

Article 5
Board of Behavioral Therapy and Health
(Licensed Professional Counselors and Alcohol and Drug Counselors)

Section 1 (148.53, subdivision 1) permits an applicant for licensure to have completed a doctoral degree program in counseling or a masters or doctoral degree in a related field as determined by the board. Requires the program to include a minimum of 48 semester hours or 72 quarter hours. Permits an applicant to demonstrate competence in professional counseling by passing a national exam that is equivalent to the National Counseling Exam as determined by the board. Removes the requirement that the specific academic course work meet standards established by the Council for Accreditation of Counseling and Related Education Programs (CACREP). Specifies that a licensed psychological practitioner is eligible to be licensed as a professional counselor and is only required to comply with the

paragraph (a), clause (4). Specifies that a licensed psychologist need only show evidence of licensure from the Board of Psychology to be licensed as a professional counselor. States that if the masters or doctoral degree is from a program that is recognized by CACREP the applicant is deemed to have met the specific course work requirements.

Section 2 (148B.53, subdivision 3) makes a technical change.

Section 3 (148B.531) permits an individual whose degree included less then the required number of hours, or did not complete the required number of hours of supervised professional practice, or did not complete the course work in all the content areas, to complete these requirements postdegree under certain conditions.

Section 4 (148B.54, subdivision 2) requires a licensee at the completion of the first four years of licensure to submit evidence of completion of 12 additional postgraduate semester credit hours or its equivalent.

Section 5 (148B.555) states that an applicant who has completed a master's or doctoral's degree program in counseling or a related field before December 31, 2003, and the degree was from a program recognized by CACREP or from an institution of higher education that is accredited by an organization recognized by the Council for Higher Education Accreditation (CHEA) does not have to comply with the education requirement so long as the applicant can document five years of full-time postdegree work experience within the practice of professional counseling. This section expires July 1, 2007.

Section 6 (148B.561) permits the board to place any disciplinary provisions that were placed on the professional counselor in another state on the license of the professional counselor in this state.

Section 7(148B.59) authorizes the board to impose disciplinary action against an applicant or licensee who has surrendered or voluntarily terminated a license or certificate during a board investigation of a complaint as part of a disciplinary order or while under an order; has been subject to a corrective action in another jurisdiction or by another regulatory authority; or has been adjudicated as mentally incompetent, mentally ill, mentally retarded, or as chemically dependent, etc. States that fee splitting includes paying, offering to pay, receiving, or agreeing to receive a commission, rebate, or remuneration, directly or indirectly, for the referral of clients.

Section 8 (148B.5901) authorizes the board to temporarily suspend the credentials of a licensee after conducting a preliminary inquiry to determine if the board reasonably believes that the licensee has violated a statute or rule and that continuing to practice would create an imminent risk of harm to others.

Section 9 (148B.5905) authorizes the board to direct an applicant or licensee to submit to a mental, physical, or chemical dependency examination or evaluation.

Section 10 (148B.5925) states that a provider is not required to provide copies of test, test materials, or scoring keys to any individual who has completed a test or to an individual not qualified to administer, score, and interpret the test if the provider determines that access would compromise the objectivity, fairness, or integrity of the testing process.

Sections 11 to 24 and 26 modify the alcohol and drug counselors' statutes.

Section 11 (148C.03, subdivision 1) removes reference to the advisory council and the requirement that the commissioner administer an examination.

Section 12 (148C.04, subdivision 3) permits before July 1, 2008, the ability for an applicant to meet licensure requirements by either completing a written case presentation and passing an oral examination or completing 2,000 hours of supervised postdegree equivalent professional practice.

Section 13 (148C.04, subdivision 4) permits after July 1, 2008, the ability for an applicant to meet licensure requirements by completing a written case presentation and passing an oral examination or submitted to the board a plan for supervision during the first 2,000 hours of professional practice, or submitted proof of supervised professional practice that is acceptable to the board.

Section 14 (148C.04, subdivision 6) makes a conforming change.

Section 15 (148C.044) establishes supervised postdegree requirements for the supervisor and the supervised practice requirements for licensure.

Section 16 (148C.091, subdivision 1) removes reference to advisory council.

Section 17 (148C.10, subdivision 2) corrects a cross-reference.

Section 18 (148C.11, subdivision 1) includes in the list of other professionals who do not need to be licensed as alcohol and drug counselors to perform functions that they are qualified or licensed to perform; social workers employed by the city, county, or state agencies and city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530. States that the board shall issue a license without examination to an applicant who is licensed or registered in a profession listed in the exceptions if the applicant:

(1) shows evidence of current licensure or registration; and

(2) has submitted a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the commissioner.

Section 19 (148C.11, subdivision 4) extends the licensure requirement for alcohol and drug counselors employed by a hospital for one year until January 1, 2007.

Section 20 (148C.11, subdivision 5) extends the licensure requirement for alcohol and drug counselors employed by a city, county, or state agency for one year until January 1, 2007.

Section 21 (148C.11, subdivision 6) modifies the transition period for hospital and city, county, and state agency alcohol and drug counselors by permitting a license to be granted if the applicant is credentialed as a board certified counselor or board certified counselor reciprocal by the Minnesota Certification Board or if the applicant has 14,000 hours of supervised alcohol and drug counselor work experience as documented by the employer.

Section 22 (148C.12, subdivision 3) increases the fee for annual renewal of a temporary permit to $150.

Section 23 (214.01, subdivision 2) removes reference to the advisory council.

Section 24 (214.103, subdivision 1) removes reference to the advisory council.

Section 25 gives the Board of Behavioral Therapy and Health the authority to use the expedited rulemaking process for adopting rules for the licensed professional counselors.

Section 26 repeals sections 148C.02 (alcohol and drug counselors licensing advisory council) and 148C.12, subdivision 4 (examination fees).

Repeals rules: 4747.0030, subpart 11 (cultural diversity committee), and subpart 16 (education committee); 4747.1200 (cultural diversity committee; and 4747.1300 (education committee).

Section 27 provides an effective date of July 1, 2005.

Article 6
Board of Medical Practice
(Physician Assistants and Respiratory Care Practitioners)

Section 1 (147A.18, subdivision1) deletes the requirement for weekly reviews by the supervising physician and replaces it with the requirement that the review be conducted as outlined in the internal protocol.

Section 2 (147A.18, subdivision 3) states that prescriptions initiated by a physician assistant must contain the name and the address of the prescribing physician assistant and removes the requirement of including the telephone number of the physician assistant and the name of the supervising physician.

Section 3 (147C.05) states that the scope of practice of respiratory care does not prohibit an individual who is licensed or registered as a respiratory therapist in another state or country from providing respiratory care in the case of an emergency, as a member of an organ harvesting team, or as part of an ambulance treatment team on board an ambulance.

Article 7
Commissioner of Health - Audiologists

Section 1 (148.512, subdivision 6) clarifies that an audiologist may be licensed under a general, clinical fellowship, doctoral externship, or temporary license.

Section 2 (148.512, subdivision 10a) defines "hearing aid."

Section 3 (148.512, subdivision 10b) defines "hearing aid dispensing."

Section 4 (148.515, subdivision 6) requires an audiologist applying for licensure on or after August 1, 2005, to achieve a passing score on the examination described in section 153A.14, paragraph (a), clause (2), unless the audiologist is licensed by reciprocity who was licensed before April 1, 2005, in another jurisdiction. Exempts audiologists from the written examination requirement in section 153A.14, subdivision 2h, paragraph (a), clause (1).

Section 5 (148.5194, subdivision 7) adds a surcharge to the audiologist licensure fee.

Section 6 148.5195, subdivision 3) adds to the list of grounds upon which the commissioner may take disciplinary action the following:

- prescribing to a consumer the use of a hearing instrument unless the prescription is in writing, is based on an audiogram that is provided to the consumer and contains specified information;
- failing to give a copy of the audiogram to the consumer when the consumer requests a copy;
- failing to provide the consumer with the consumer rights brochure;
- failing to comply with the restrictions on sales of hearing aids; and
- failing to return a consumer's hearing aid used as a trade in or for a discount in the price of a new hearing aid when requested by the consumer upon cancellation of the purchase agreement.

Section 7 (148.5197) establishes hearing instrument dispensing provisions.

Subdivision 1 states that all oral statements made by the audiologist regarding warranties, refunds, and service must be written and must be part of the contract of sale, must specify the item or items covered, and the person or entity that is obligated to provide the warranty, refund, or service.

Subdivision 2 requires the audiologist's license number must appear on all contracts, bills of sale, and receipts.

Subdivision 3 requires an audiologist to give the consumer the consumer rights brochure at the time of a recommendation or prescription. States what the brochure must contain and states that a sales contract must note that the brochure was received by the buyer along with the buyer's signature or initials.

Subdivision 4 states who is liable for satisfying the terms of a contract either written or oral. The commissioner may enforce the terms of the sales contract against the principal, employer, supervisor, or dispenser who conducted the sale and may impose any remedy provided under this chapter.

Section 8 (148.5198) establishes restrictions on the sale of hearing aids.

Subdivision 1 establishes the 45-calendar-day guarantee and buyers right to cancel.

Subdivision 2 requires the audiologist or company who agrees to repair a hearing aid to provide a bill that describes the repair and service rendered.

Subdivision 3 requires any guarantee of a hearing aid to be in writing and delivered to the owner of the hearing aid.

Subdivision 4 states that any person who violates this section is guilty of a misdemeanor.

Subdivision 5 states that in addition to being guilty of a misdemeanor, the person is subject to the penalties and remedies in section 325F.69, subdivision 1 (fraud, misrepresentation, and deceptive practices).

Subdivision 6 requires an audiologist or company to provide the owner of a hearing aid with a written estimate of the price of repairs, upon request, and that the audiologist must not charge more than the total price stated on the estimate.

Sections 9 to 14 make conforming changes to chapter 153A (hearing instrument dispensing).

Section 9 (153A.13, subdivision 5) permits a licensed audiologist to dispense a hearing instrument without being certified by the commissioner.

Section 10 (153A.14, subdivision 2i) removes a reference to audiologists.

Section 11 (153A.14, subdivision 4) makes a conforming technical change.

Section 12 (153A.14, subdivision 4c) removes a reference to audiologists.

Section 13 (153A.15, subdivision 1) makes a conforming change to the information that must be provided by a hearing instrument dispenser clarifying that a prescription for a hearing instrument may be purchased from a licensed audiologist as well as a certified dispenser.

Section 14 (153A.20, subdivision 1) makes a conforming change to the hearing dispenser advisory council in that the audiologists on the council do not have to be certified hearing dispensers.

Section 15 instructs the Revisor to make conforming changes.

Section 16 repeals section 153A.14, subdivision 2a (exemption from written examination requirement for audiologists).

Section 17 is an effective date of August 1, 2005.

Article 8
Office of Mental Health Practices Committee

Section 1 (148B.60) adds to the definition of "mental health services" behavioral health care, spiritual counseling, and hypnosis when not for entertainment. Adds a definition for "mental-health-related licensing boards" that includes the Boards of Medical Practice, Nursing, Psychology, Social Work, Marriage and Family Therapy, and Behavioral Health and Therapy. Adds a definition for "committee" that shall consist of one member appointed from each of the mental-health-related licensing boards. Makes other technical changes.

Section 2 (148B.61) makes changes to the Office of Mental Health Practice.

Subdivision 1 transfers the Office of Mental Health Practice to the mental-health-related licensing boards. Requires the office to publish a complaint telephone number, provide an informational Web site, and to serve as a referral point and clearinghouse on complaints against mental health practitioners.

Subdivision 4, paragraph (a), requires the committee to:

(1) designate one board to provide administrative management of the program;

(2) set the program budget; and

(3) ensure that the program's direction is in accord with its authority.

Paragraph (b) states that if the participating boards change which board is designated to provide administrative management of the program, any appropriation remaining shall transfer to the newly designated board. Requires the participating boards to inform the appropriated legislative committees and the Commissioner of Finance of the change and the amount of any appropriation transferred.

Paragraph (c) requires the designated board to hire the office employees and pay expenses of the program from the appropriated funds.

Paragraph (d) requires the committee to prepare and submit a report to the Legislature by January 15, 2009, evaluating the activity of the office and making recommendations on the regulation of unlicensed mental health practitioners. States that the committee and office expires on June 30, 2009, unless legislative action is taken to continue the office.

Section 3 delays the expiration of the unlicensed mental health practice statutes until July 1, 2009. (Currently, these statutes are scheduled to expire July 1, 2005.)

Section 4 appropriates money from the state government special revenue fund to the mental-health-related licensing boards as nonrecovery funds.

Section 5 instructs the Revisor to insert "committee" where the "Commissioner of Health" appears in Minnesota Statutes, sections 148B.60 to 148B.71.

Section 6 is an effective date of July 1, 2005.

Article 9
Miscellaneous

Sections 1 to 3 (148.5194, subdivision 7; 148.6445, subdivision 11; and 148C.12, subdivision 11) establish the following penalty fees for speech language pathologists, audiologists, and occupational therapists:

- For practicing without a current license, the penalty is the amount of the license renewal fee for any part of the first month, plus the license renewal fee for any subsequent month up to 36 months;

- For practicing before a license is issued, the penalty is the amount of the license application fee for any part of the first month, plus the license application fee for any part of any subsequent month up to 36 months;

- For failing to submit continuing education reports, the penalty is $100, plus $20 for each missing clock hour and the licensee must complete the required number of hours by the end of the next reporting due date; and

- States that civil penalties and discipline incurred by licensees before August 1, 2005, for any of the above reasons are to be recorded as nondisciplinary penalty fees and after August 1, 2005, the payment of a penalty for practicing without a license or before a license is issued for a period longer than 12 months does not preclude further disciplinary action if justified by the individual case.

Section 4 (153A.175) establishes the following penalties for hearing instrument dispensers:

- For practicing with an expired certificate, the penalty is one-half the amount of the certificate renewal fee for any part of the first day, plus one half the certificate renewal fee for any part of any subsequent days up to 30 days;

- For practicing after expiration of the trainee period and before a certificate is issued, the penalty is one-half the amount of the certificate application fee for any part of the first day, plus one half the certificate application fee for any part of any subsequent days up to 30 days;

- For failing to submit continuing education reports, the penalty is $200, plus $200 for each missing clock hour and the dispenser must complete the required clock hours by the next reporting due date; and

- States that civil penalties and discipline incurred before August 1, 2005, for any of the reasons stated above will be recorded as nondisciplinary penalty fees but payment of a penalty does not preclude disciplinary action if justified by the individual case.

KC:ph

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agencies: Social Work Board
Psychology Board
Physical Therapy, Board of
Dentistry Board
Behavioral Health & Therapy Bd
Medical Practice Board

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
Health Related Boards Fund					
Behavioral Health & Therapy Bd					
Revenues					
Health Related Boards Fund		(20)	(15)	(15)	(15)
Dentistry Board		3	3	3	3
Psychology Board					
Behavioral Health & Therapy Bd		(23)	(18)	(18)	(18)
Net Cost <Savings>					
Health Related Boards Fund		20	15	15	15
Dentistry Board		(3)	(3)	(3)	(3)
Psychology Board					
Behavioral Health & Therapy Bd		23	18	18	18
Total Cost <Savings> to the State		20	15	15	15

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Agency Name: Social Work Board

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

This bill version has no fiscal effect on our agency.

FN Coord Signature: JULI VANGSNESS
Date: 04/12/05 Phone: 617-2120

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Agency Name: Dentistry Board

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
Health Related Boards Fund		3	3	3	3
Net Cost <Savings>					
Health Related Boards Fund		(3)	(3)	(3)	(3)
Total Cost <Savings> to the State		(3)	(3)	(3)	(3)

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

Bill Description

SF1204-1E places existing Board of Dentistry fees established in Rule into MN Statute, increases the fee for duplicate licenses, initiates a new fee for applications for anesthesia/conscious sedation permits, and (in the original HF1865) proposes a change related to supervision levels in Collaborative Agreements.

Assumptions

- The fee structure has been established in Rule
- The Board is now required to address fees legislatively (in statute)
- The fees reflect annualized rates that have been applied to recently adopted and implemented (2004) biennial cycles
- The fee for duplicate licenses must be raised to cover costs
- Applications for anesthesia/conscious sedation permits are increasing in volume, and review of the applications involves staff and Board member time and money
- On-site anesthesia/sedation inspection fees are paid to the third party conducting the inspection

Expenditure and/or Revenue Formula

Fee Increase

1. *Duplicate Licenses*
   Current: ~130 duplicate licenses per year @ $20 = $ 2,600
   Proposed: ~130 duplicate licenses per year @ $35 = $ 4,550

   Expenditures remain stable; revenues increase by **$ 1,950/yr** to cover duplicate license costs

New Fee

2. Anesthesia/Conscious Sedation Permits
   Proposed: ~25 permits per year @ $50 = $ 1,250

   Revenues increase by **$1,250/yr** related to anesthesia/sedation permit application review

Long-Term Fiscal Considerations

The change from annual to biennial license renewal allows the Board to better manage work flow, and significantly reduces the need for overtime and temporary staff.

The fee changes for duplicate licenses and anesthesia permits reflect the Board's position that appropriate charges should be assessed to cover costs of additional services requested.

Local Government Costs

None

References/Sources

N/A

FN Coord Signature: JULI VANGSNESS
Date: 04/12/05 Phone: 617-2120

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Medical Practice Board

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

Bill Description

SF 1204-1E
Omnibus health occupations bill. In part, transfers Office of Mental Health Practice to the Mental Health Related Licensing Boards (Social Work, Psychology, Marriage & Family Therapy, Medical Practice and Nursing). Requires each board to appoint one member to the Office of Mental Health Practice Committee. The committee will designate an administrating board.

Assumptions

All costs associated with administrating the profession will be taken from the health related boards special revenue fund.

Each board will be responsible for reimbursement of their appointed committee member. The designated committee member for Medical Practice will participate and be reimbursed for no more then six meetings per year @ $55.00 per day.

Expenditure and/or Revenue Formula

$55.00 x 6 = $330 in per diems expenses each year of the biennium.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

FN Coord Signature: JULI VANGSNESS
Date: 04/14/05 Phone: 617-2120

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agency Name: Behavioral Health & Therapy Bd

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Health Related Boards Fund					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Health Related Boards Fund					
Revenues					
Health Related Boards Fund		(23)	(18)	(18)	(18)
Net Cost <Savings>					
Health Related Boards Fund		23	18	18	18
Total Cost <Savings> to the State		23	18	18	18

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description
SF – 1204-1E

Portion of bill relating to licensed professional counselors:
First, modifying certain provisions governing the licensing of licensed professional counselors (LPC) by the Board of Behavioral Health and Therapy; broadening certain general requirements for licensure qualification purposes; permitting post-degree completion of certain degree requirements for licensure under certain conditions; modifying certain continuing education requirements; providing for certain retaliatory actions; expanding the grounds for disciplinary action; authorizing and providing for temporary suspension of licenses under certain conditions; authorizing the board to require submission to mental, physical or chemical dependency examination or evaluations upon probable cause, failure to submit to constitutes an admission of the allegations, exception, granting the board access to certain medical data and health records; providing for assessment tool security; authorizing the board to use the expedited rulemaking process to adapt and amend rules for conformity purposes.

Second, the addition of a two-year "grandparenting" period will qualify some counselors with five years of experience post-degree to be licensed with the board.

Portion of bill relating to licensed alcohol and drug counselors:
First, regarding alcohol and drug counselors (ADC) licensing and amendments to Minnesota Statutes Ch. 148C only, and beginning with section 11, the bill modifies the commissioner's duties by deleting responsibility to administer written and oral examination, creates an option to obtain 2,000 hours of supervised post-degree professional practice in lieu of the oral examination requirement to qualify for licensure, defines the content of supervised post-degree professional practice and the requirements for supervisors, changes the transition period requirements for hospital and public employees and repeals the alcohol and drug counselor advisory council and its committees.

Second, the bill extends the dates requiring licensing for hospital and public employees from January 1, 2006 to January 1, 2007. The bill also clarifies exemption language, creates an option to obtain 2,000 hours of supervision in lieu of an examination requirement for applicants licensed or registered in a profession excepted from the licensing requirements, creates an additional option in the transition requirements for hospital and public employees to become licensed and increases the temporary permit renewal fee from $100 to $150 per year.

Assumptions
Portion of bill relating to licensed professional counselors:
First, the primary purpose of this bill is house keeping - it also includes provisions on temporary suspension of licensed professional counselors, post-degree completion of requirements for licensure, and a two-year grandparenting provision for experienced counselors to obtain licensure.

This bill will allow more individuals to become licensed under the licensed professional counselor licensure requirements. This bill allows individuals to take specific courses or complete necessary additional graduate credits or supervision hours in order to qualify for licensure.

Second, the board assumes that additional individuals will be eligible for licensure through the "grandparenting" provision. The board anticipates that this bill will allow several hundred individuals to be eligible for licensure should they choose to apply for licensure.

Portion of bill relating to licensed alcohol and drug counselors:
First, effective July 1, 2005, administration of the licensing system for alcohol and drug counselors transfers from the Minnesota Department of Health (MDH) to the Board of Behavioral Health and Therapy (BBHT). Therefore, the bill has a fiscal impact for the BBHT beginning FY 2006.

BBHT – assumes FY 05 estimated expenditures and revenues at MDH are the same each year in the future biennia at BBHT.

Eliminating the requirement to administer examinations will reduce staff administrative time and supply expenditures and eliminate revenues from exam fees. Creation of an option to obtain 2,000 hours of supervised post-degree professional practice in lieu of the examination requirement to qualify for licensing will not significantly increase administrative expenses because the option will utilize existing licensing forms and procedures. Deletion of the transition period requirements from hospital and public employees will eliminate use of a form and has no fiscal impact.

Eliminating advisory council and advisory committees will reduce staff administrative time and supply expenditures.

Second, according to the MDH – the original estimates and assumptions about applicants for alcohol and drug counselor licensing did not include hospital and public employees and were not adjusted when the exceptions to licensing requirements were repealed in 2003. Therefore, there are no effects to account for in the revenue and expense projections for processing new applicants for licenses or by extending the licensing requirement one year.

Renewal of temporary permits occurs annually on July 31st, and the deadline for submitting the renewal application and fee is June 30th. The effective date of acts without appropriations is August 1st following each legislative session unless a different date is specified. Therefore, there is no fiscal impact in FY 06.

Expenditure and/or Revenue Formula

Portion of bill relating to licensed professional counselors:

This bill will not generate more revenue than what the board originally anticipated when it was first established because when the board was first established, the original number of potential LPC licensees was overestimated. In addition, the original licensure language had very little flexibility and actually prevented many individuals from qualifying for licensure. The hypothesis at the time the LPC credential was established was that the BBHT would capture almost all of the unlicensed mental health practitioners (MDH provided a figure of about 3000 unlicensed practitioners at that time) and be able to license them as LPCs. That turned out not to be the case, and the number of applicants and licensees was only about 12 percent of that number.

This bill will broaden the opportunity for licensure and allow more individuals to be licensed. However, it is not possible to estimate how many people will take advantage of the grandparenting option or the options now proposed under the general requirements for licensure which permit someone to complete courses or supervised field experience post-degree in order to be able to qualify for licensure. Even with the flexibility afforded to applicants by the language in this bill, it will take a period of time before the number of applicants and licensees approaches the estimates made when the board was first established.

Portion of bill relating to licensed alcohol and drug counselors:

The following fiscal impact has been provided to the BBHT for inclusion in the BBHT fiscal note by MDH.

According to MDH, a reduction of $65,462 in salary, benefit and supplies and exam expenditures will occur as a result of a total .5 reduction in FTE of staff and activities associated with administration of 6 examination and 12 to 15 advisory group meetings each year. However, this reduction estimate may not actually occur at all. First, although the examination duties are being eliminated, staff will need to track applicants' supervision and the qualifications of supervisors and there will be administrative costs related to this duty. Second, only two FTE staff are transferring from MDH to the BBHT. The transferring staff members' duties are with the licensure process. The transferring staff does not have responsibility for complaint or background investigations. Funds will need to be used to hire investigative staff at the board office or to pay the Attorney General's Office for investigative services.

Written and oral exam fee revenue in the amount of $23,000 will be eliminated.

Licensing fees and other revenues are not affected.

Second, currently there are 132 temporary permit holders, but only about 100 are expected to renew. The current renewal fee is $100. An increase of $50 times 100 persons produces additional revenue of $5,000.00 per year, beginning in FY 07.

Long-Term Fiscal Considerations

Portion of bill relating to licensed professional counselors:

Any fiscal impact will be long term and indirect. The bill if passed should result in more applicants for LPC licensure. This should result in additional revenue for the board. The original bill prevented many individuals from qualifying for licensure – this bill should allow more individuals to become LPC's.

Portion of bill relating to licensed alcohol and drug counselors:

First, reduction in expenditures for regulating ADC's does not cause a reduction of licensing fees at this time. At

the beginning of FY 06, the account balance for the ADC licensing activity was ($1,049,000) deficit. Beginning FY 03 this deficit as amortized with a ten-year licensing surcharge fee of $99. Cost savings from reductions in regulatory expenditures will accrue to the account deficit and may allow repeal of the surcharge ahead of its scheduled expiration in FY 13.

Second, repealing the written and oral examination testing fees should result in more efficient operation of the licensure program for alcohol and drug counselors because applicants will communicate directly with testing entities and the state will no longer have to process the fees. It is unknown whether this change will significantly affect the costs related to staff time devoted to this activity, because staff will now have to track supervision documentation for those applicants who elect that route to licensure.

Local Government Costs

Portion of bill relating to licensed professional counselors:

Portion of bill relating to licensed alcohol and drug counselors:

References/Sources

Portion of bill relating to licensed professional counselors:

Portion of bill relating to licensed alcohol and drug counselors:

Agency Contact Name: Kari Rechtzigel (612-617-2192)

FN Coord Signature: JULI VANGSNESS
Date: 04/19/05 Phone: 617-2120

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Agency Name: Physical Therapy, Board of

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

SF 1204-1E Health Occup Violations Penalty Fees

Article 2 pertains to the Physical Therapists Practice Act - moving definitions of physical therapists assistants and physical therapy aides from rule to statute; adding definitions of student PT's and PTA's; addition of provisions for cancellation of a PT license; adding grounds for discipline related to supervision and delegation to students, and for practice under lapsed or non-renewed credentials; adding provision for mental or physical examination; adding temporary suspension provision; and providing for the issuance of a physical therapist license based on PT licenses in 3 other states and one foreign country between 1980 and 1995.

Assumptions

The entire bill will not add cost for the board. The majority of the bill is adding definitions that will not add cost to the board. The special conditions for issuing a PT license (PT licensure in 3 other states and 1 foreign country between 1980 and 1995) will apply to only one individual.

Expenditure and/or Revenue Formula

N/A

Long-Term Fiscal Considerations

No

Local Government Costs

No

FN Coord Signature: JULI VANGSNESS
Date: 04/12/05 Phone: 617-2120

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1204-1E **Complete Date:**

Chief Author: KISCADEN, SHEILA

Title: HEALTH OCCUP LICENSING PROVISIONS

Agency Name: Psychology Board

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
Health Related Boards Fund					
Net Cost <Savings>					
Health Related Boards Fund					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

SF 1204-1E

Article 3 of this bill contains a number of housekeeping changes to the Psychology Practice Act. It also allows for the conversion of qualified Licensed Psychological Practitioners (LPP) to Licensed Psychologist (LP) licensure and then it sunsets LPP licensure.

Assumptions:

Article 3 takes into account the fact that LPP licensure has been available in Minnesota since 1991, yet the Board of Psychology only has approximately 53 individuals licensed as LPP's. It is not a licensure option that is attractive to psychology graduates because of the difficulties LPP's have obtaining employment. The LPP license is not a license for independent practice, meaning that licensees at this level must be supervised throughout their careers. They have found that potential employers do not want to hire LPP's and pay someone to supervise them. Paying for supervision themselves is expensive. LPP's have found that most third party payers will not reimburse agencies for services provided by LPP's because it is not an independent license.

Expenditure and/or Revenue Formula:

LPP's as a level of licensure are not a drain on the Psychology Board's budget and are a minor source of revenue. The fiscal impact of eliminating this level of licensure will be minimal.

1. Applicants must complete applications for admission to the exams by 12/31/05
2. Applicants must pass the exams by 12/31/06
3. Applicants must complete applications for licensure by 03/01/07
4. LPP licensure will sunset by 12/31/11

During this time frame qualified applicants will apply for the conversion from LPP to LP licensure. Revenue from LPP licensure will increase during the conversion period, and then decline. Since licensure renewal is every two years, revenue from LP licensure will slightly increase following the conversion period.

Long-Term Fiscal Considerations:

Eliminating LPP licensure will not result in any long-term fiscal impact since after 14 years of having this licensure available in the state, only 53 individuals maintain LPP licensure. Each fiscal year, the agency has traditionally averaged about 1-3 new LPP's. The agency believes 14 years of experience to be indicative of the future.

Local Government Costs:

Since the Board of Psychology is totally fee supported, there are no costs to local governments.

References/Sources:

FN Coord Signature: JULI VANGSNESS
Date: 04/12/05 Phone: 617-2120

Minnesota Provider Coalition

1300 Godward Street NE Suite 2000-2200 * Minneapolis, MN 55413

Jack Davis
Chief Executive Officer
Hennepin Medical Society
612-623-2899
jdavis@metrodoctors.com

Roger Johnson
Chief Executive Officer
Ramsey Medical Society
612-362-3799
rjohnson@metrodoctors.com

MEMBERS

Advocates for Marketplace Options for Mainstreet (AMOM)

Association of Community Mental Health Programs, Inc.

Citizen's Council on Health Care

Hennepin Medical Society

Metropolitan Anesthesia Network LLP

Minnesota Chapter American Physical Therapy Association

Minnesota Chiropractic Association

Minnesota Dental Association

Minnesota Medical Group Management Association

Minnesota Nurses Association

Minnesota Occupational Therapy Association

Minnesota Pharmacists Association

Minnesota Physician Patient Alliance

Minnesota Podiatric Medical Association

Minnesota Psychiatric Society

Minnesota Rural Health Cooperative

Northstar Physicians

Northwestern Health Sciences University

Ramsey Medical Society

April 19, 2005

Dear Members of the Minnesota Senate:

On behalf of the member organizations of the Minnesota Provider Coalition, which are listed to the left and their individual members, we urge you to oppose Section 13 (lines 105.7 thru 105.13) of S.F.1204. This section reads as follows:

105.7 Sec. 13. [LICENSE ISSUANCE.]
105.8 Notwithstanding Minnesota Statutes, sections 148.65 to
105.9 148.78, the Board of Physical Therapy shall grant a physical
105.10 therapist license to an individual who has been issued physical
105.11 therapy licenses between 1980 and 1995 in at least three other
105.12 states and at least one foreign country and who applies before
105.13 August 1, 2005.

The Minnesota Provider Coalition does not support lowering licensing standards (for any profession) for just one person. This section allows for issuance of one license to practice physical therapy in the state of Minnesota without examination.

We urge you to appose Section 13 of S.F. 1204.

Sincerely,

Jack G. Davis, Chair

SENATE
STATE OF MINNESOTA
EIGHTY-FOURTH LEGISLATURE

S.F. No. 1115

(SENATE AUTHORS: FISCHBACH, Lourey, Kelley, Gaither and Moua; Companion to H.F. No. 1370.)

DATE	D-PG	OFFICIAL STATUS
02/21/2005	444	Introduction and first reading
02/21/2005		Referred to Health and Family Security
03/10/2005	667a	Comm rpt: To pass as amend & re-ref to State an Local Government Operations
03/29/2005		Committee report: To pass
03/29/2005		Second reading

A bill for an act

relating to occupations; requiring plumbers to be licensed; establishing inspection requirements for new plumbing installations; allowing the commissioner to charge fees to hire staff; licensing restricted plumbing contractors; requiring rulemaking; amending Minnesota Statutes 2004, sections 144.122; 326.01, by adding a subdivision; 326.37, subdivision 1, by adding a subdivision; 326.38; 326.40, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 326; repealing Minnesota Statutes 2004, section 326.45.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.122, is amended to read:

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

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

permissioner may also prescribe, by rule, reduced fees for

permits, licenses, registrations, and certifications when the

application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner shall adopt reasonable rules establishing criteria and procedures for refusal to grant or renew licenses and registrations, and for suspension and revocation of licenses and registrations.

(c) The commissioner may refuse to grant or renew licenses and registrations, or suspend or revoke licenses and registrations, in accordance with the commissioner's criteria and procedures as adopted by rule.

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

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

~~(d)~~ (f) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals) $7,055

Non-JCAHO hospitals	$4,680 plus $234 per bed
Nursing home	$183 plus $91 per bed

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

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

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

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

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

(h) The commissioner shall charge the following fees for examinations, registrations, licenses, and inspections:

Plumbing examination	$ 50
Water conditioning examination	$ 50
Plumbing bond registration fee	$ 40
Water conditioning bond registration fee	$ 40
Master plumber's license	$120
Restricted plumbing contractor license	$ 90
Journeyman plumber's license	$ 55
Apprentice registration	$ 25
Water conditioning contractor license	$ 70
Water conditioning installer license	$ 35
Residential inspection fee (each visit)	$ 50

Public, commercial, and industrial inspections	Inspection fee
25 or fewer drainage fixture units	$ 300
26 to 50 drainage fixture units	$ 900
51 to 150 drainage fixture units	$1,200
151 to 249 drainage fixture units	$1,500
250 or more drainage fixture units	$1,800
Callback fee (each visit)	$ 100

(i) Plumbing installations that require only fixture installation or replacement require a minimum of one inspection. Residence remodeling involving plumbing installations requires a minimum of two inspections. New residential plumbing installations require a minimum of three inspections. For purposes of this paragraph and paragraph (h), residences of more than four units are considered commercial.

Sec. 2. Minnesota Statutes 2004, section 326.01, is amended by adding a subdivision to read:

Subd. 9a. [RESTRICTED PLUMBING CONTRACTOR.] A "restricted

plumbing contractor" is any person skilled in the planning, superintending, and practical installation of plumbing who is otherwise lawfully qualified to contract for plumbing and installations and to conduct the business of plumbing, who is familiar with the laws and rules governing the business of plumbing, and who performs the plumbing trade in cities and towns with a population of fewer than 5,000 according to federal census.

Sec. 3. Minnesota Statutes 2004, section 326.37, subdivision 1, is amended to read:

Subdivision 1. [RULES.] The state commissioner of health ~~may~~ shall, by rule, prescribe minimum uniform standards ~~which shall be uniform, and which standards shall thereafter be~~ effective for all new plumbing installations, including additions, extensions, alterations, and replacements ~~connected with any water or sewage disposal system owned or operated by or for any municipality, institution, factory, office building, hotel, apartment building, or any other place of business regardless of location or the population of the city or town in which located~~. Notwithstanding the provisions of Minnesota Rules, part 4715.3130, as they apply to review of plans and specifications, the commissioner may allow plumbing construction, alteration, or extension to proceed without approval of the plans or specifications by the commissioner.

The commissioner shall administer the provisions of sections 326.37 to ~~326.45~~ 326.451 and for such purposes may employ plumbing inspectors and other assistants.

Sec. 4. Minnesota Statutes 2004, section 326.37, is amended by adding a subdivision to read:

Subd. 1a. [INSPECTION.] All new plumbing installations, including additions, extensions, alterations, and replacements, shall be inspected by the commissioner for compliance with accepted standards of construction for health, safety to life and property, and compliance with applicable codes. The Department of Health must have full implementation of its inspections plan in place and operational July 1, 2007. This

subdivision does not apply where a political subdivision requires, by ordinance, plumbing inspections similar to the requirements of this subdivision.

Sec. 5. Minnesota Statutes 2004, section 326.38, is amended to read:

326.38 [LOCAL REGULATIONS.]

Any city having a system of waterworks or sewerage, or any town in which reside over 5,000 people exclusive of any statutory cities located therein, or the metropolitan airports commission, may, by ordinance, adopt local regulations providing for plumbing permits, bonds, approval of plans, and inspections of plumbing, which regulations are not in conflict with the plumbing standards on the same subject prescribed by the state commissioner of health. No city or such town shall prohibit plumbers licensed by the state commissioner of health from engaging in or working at the business, except cities and statutory cities which, prior to April 21, 1933, by ordinance required the licensing of plumbers. No city or such town may require a license for persons performing building sewer or water service installation who have completed pipe laying training as prescribed by the commissioner of health. Any city by ordinance may prescribe regulations, reasonable standards, and inspections and grant permits to any person, firm, or corporation engaged in the business of installing water softeners, who is not licensed as a master plumber or journeyman plumber by the state commissioner of health, to connect water softening and water filtering equipment to private residence water distribution systems, where provision has been previously made therefor and openings left for that purpose or by use of cold water connections to a domestic water heater; where it is not necessary to rearrange, make any extension or alteration of, or addition to any pipe, fixture or plumbing connected with the water system except to connect the water softener, and provided the connections so made comply with minimum standards prescribed by the state commissioner of health.

Sec. 6. Minnesota Statutes 2004, section 326.40,

subdivision 1, is amended to read:

Subdivision 1. [~~PLUMBERS MUST BE LICENSED IN CERTAIN CITIES; MASTER AND JOURNEYMAN PLUMBERS~~ MASTER, JOURNEYMAN, AND RESTRICTED PLUMBING CONTRACTORS; PLUMBING ON ONE'S OWN PREMISES; RULES FOR EXAMINATION.] ~~In any city now or hereafter having 5,000 or more population, according to the last federal census, and having a system of waterworks or sewerage, no person, firm, or corporation shall engage in or work at the business of a master plumber or journeyman plumber unless licensed to do so by the state commissioner of health.~~ No person, firm, or corporation may engage in or work at the business of a master plumber, restricted plumbing contractor, or journeyman plumber unless licensed to do so by the commissioner of health under sections 326.37 to 326.451. A license is not required for:

(1) persons performing building sewer or water service installation who have completed pipe laying training as prescribed by the commissioner of health; or

(2) persons selling an appliance plumbing installation service at point of sale if the installation work is performed by a plumber licensed under sections 326.37 to 326.451.

A master plumber may also work as a journeyman plumber. Anyone not so licensed may do plumbing work which complies with the provisions of the minimum standard prescribed by the state commissioner of health on premises or that part of premises owned and actually occupied by the worker as a residence, unless otherwise forbidden to do so by a local ordinance.

~~In any such city~~ No person, firm, or corporation shall engage in the business of installing plumbing nor install plumbing in connection with the dealing in and selling of plumbing material and supplies unless at all times a licensed master plumber or restricted plumbing contractor, who shall be responsible for proper installation, is in charge of the plumbing work of the person, firm, or corporation.

The Department of Health shall prescribe rules, not inconsistent herewith, for the examination and licensing of plumbers.

Sec. 7. [326.402] [RESTRICTED PLUMBING CONTRACTOR LICENSE.]

Subdivision 1. [LICENSURE.] The commissioner shall grant a restricted plumbing contractor license to any person who applies to the commissioner and provides evidence of having at least two years of practical plumbing experience in the plumbing trade preceding application for licensure.

Subd. 2. [USE OF LICENSE.] A restricted plumbing contractor may engage in the plumbing trade only in cities and towns with a population of fewer than 5,000 according to federal census.

Subd. 3. [APPLICATION PERIOD.] Applications for restricted plumbing contractor licenses must be submitted to the commissioner prior to January 1, 2006.

Subd. 4. [USE PERIOD FOR RESTRICTED PLUMBING CONTRACTOR LICENSE.] A restricted plumbing contractor license does not expire and remains in effect for as long as that person engages in the plumbing trade.

Subd. 5. [PROHIBITION OF TRANSFERENCE.] A restricted plumbing contractor license must not be transferred or sold to any other person.

Subd. 6. [RESTRICTED PLUMBING CONTRACTOR LICENSE RENEWAL.] The commissioner shall adopt rules for renewal of the restricted plumbing contractor license.

Sec. 8. [326.451] [INSPECTORS.]

(a) The commissioner shall set all reasonable criteria and procedures by rule for inspector certification, certification period, examinations, examination fees, certification fees, and renewal of certifications.

(b) The commissioner shall adopt reasonable rules establishing criteria and procedures for refusal to grant or renew inspector certifications, and for suspension and revocation of inspector certifications.

(c) The commissioner shall refuse to renew or grant inspector certifications, or suspend or revoke inspector certifications, in accordance with the commissioner's criteria

and procedures as adopted by rule.

Sec. 9. [REVISOR'S INSTRUCTION.]

The revisor of statutes shall change all references to Minnesota Statutes, section 326.45, to Minnesota Statutes, section 326.451, in Minnesota Statutes, sections 144.99, 326.44, 326.61, and 326.65.

Sec. 10. [REPEALER.]

Minnesota Statutes 2004, section 326.45, is repealed.

Sec. 11. [EFFECTIVE DATE.]

Sections 1 to 8 and 10 are effective July 1, 2005.

Fiscal Note – 2005-06 Session

Bill #: S1115-1E **Complete Date:** 04/04/05

Chief Author: FISCHBACH, MICHELLE

Title: PLUMBERS LICENSING & INSPECTION REQ

Agency Name: Health Dept

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
State Govt Special Revenue Fund		941	6,228	6,228	6,228
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
State Govt Special Revenue Fund		941	6,228	6,228	6,228
Revenues					
State Govt Special Revenue Fund		2,640	4,780	5,531	6,282
Net Cost <Savings>					
State Govt Special Revenue Fund		(1,699)	1,448	697	(54)
Total Cost <Savings> to the State		(1,699)	1,448	697	(54)

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
State Govt Special Revenue Fund		11.00	14.00	14.00	14.00
Total FTE		11.00	14.00	14.00	14.00

Bill Description

Requiring and providing for the licensing of plumbers by the commissioner of health; requiring the commissioner to adopt rules establishing criteria and procedures for denial, refusal to renew, suspension and revocation of licenses and registrations under the authority of the commissioner and granting the commissioner the authority to deny, refuse to renew, suspend or revoke licenses and registrations in accordance with the adopted criteria and procedures; establishing a fee schedule for plumber examinations, bond and apprentice registrations, licenses, and inspections and specifying certain minimum plumbing installation inspection requirements; defining restricted plumbing contractor for licensing purposes; making mandatory the option of the commissioner to by rule prescribe minimum uniform standards for new plumbing installations; requiring commissioner inspection of new plumbing installations for compliance with accepted standards of construction for health and safety and for compliance with applicable codes, exceptions, requiring full implementation and operation of an inspection plan by a certain date; prohibiting city, town or state license requirements for persons installing building sewer or water service completing pipe laying training prescribed by the commissioner; requiring commissioner licensing of master, journeyman and restricted plumbing contractors and specifying certain requirements for licensing as a restricted plumbing contractor; requiring the commissioner to establish criteria and procedures by rule for inspector certification and examination; specifying certain reference change instructions to the revisor of statutes.

Assumptions

A number of provisions of this bill have no implications for staffing. However, the legislation will provide for services that include inspections of all installations of plumbing across the state not done by local officials, and extending licensing to plumbers currently not required to hold a license since they do not work in cities of 5,000 or greater. Activities associated with the new license requirement for currently unlicensed plumbers will be funded by new fees. There are an estimated 5,000 unlicensed plumbers in Minnesota.

Inspections in this program will be done by inspectors hired on contract in a system analogous to that carried out by the Board of Electricity for electrical inspections. Based on recent estimates of new home construction and remodeling for homes not on municipal water and sewer services, and the number of plumbing plans received for review by MDH each year for public and commercial buildings, an estimated 80,000 inspections will be required each year. Based on travel and inspection time estimates, 58 contract inspectors will be required to provide these inspections and fees are set to cover the contract costs. The budget and staff levels are phased in during FY 06 through FY 08 to allow staff training and program development

MDH staff references in this note will carry out responsibilities in the following areas:

- Coordination of inspection program for 58 contract inspectors, including distribution of an estimated 80,000 inspection requests and reports, training, technical assistance and code interpretation, and code compliance enforcement activities (1 Plumbing Standards Rep, 6 field inspectors and 1 supervisor, and 4 associated support staff). Technical staff would be knowledgeable in the plumbing code and capable of field inspections. The staff may also be involved in licensing and examination activities. Support staff would assist with correspondence and reports. With current staff plus the proposed additions, there will be about 1 MDH technical staff person for each 5 contract inspectors.
- Inspection information management, e.g. requests and reports (1 data management staff).

The inspector certification program for an estimated 1,000 inspectors will be funded through examination fees.

EXPENDITURES

- Contract inspectors to be hired for approximately $80,000 each which is analogous to the amount paid by the Board of Electricity to contractors for electrical inspections. This cost includes salary, travel, and supplies.
- Assume 3 inspections average per residential project = (6,020 + 14,000)*3 = 60,060 inspections per year.
- Assume 7 inspections average per public/commercial project = 2,850*7 = 19,950 inspections per year.
- Assume 5 inspections average per day per inspector.
- 60,060 + 19,950 = 80,010 or 80,000 inspections per year.
- Assume 240 work days per year (assuming 52 weekends, 11 holidays, and 10 days vacation or sick leave.

- 80,000 inspections / 240 work days per year = 330 inspections per day.
- 330 inspections per day / 5-6 inspections per day per inspector = 55-66 contract inspectors total (assume 58.
- Assume 58 contract inspectors require technical assistance on a 1 to 5 basis = 11 or 12 tech reps.
- Assume plumbing standard representatives and field inspectors serve as both inspectors and technical assistance providers. .

September 1, 2005 to June 30, 2006	Staff	Salary	10 months Total	
Plumbing Std. Rep.	1	$48,600	$40,500	
Data Management	1	$44,100	$36,750	
Field Inspectors	6	$49,680	$248,400	
Field Supervisors	1	$54,450	$45,375	
Support Staff	2	$27,000	$45,000	
Subtotal	**11**		**$416,025**	
Fringe Costs (29%)			$120,647	
Total salary and fringe				$536,672
Supplies and Expenses			$230,000	
Equipment		$26,000	$26,000	
Indirect costs (19.4%)			$148,734	
Total Supplies and Expenses				$404,734
FY06 Expenditures (10 months)				**$941,406**
FY 2007 forward				
Plumbing Std. Rep.	1	$48,600	$48,600	
Data Management	1	$44,100	$44,100	
Support Staff	4	$27,000	$108,000	
Office Support Supervisor	1	$36,900	$36,900	
Field Inspectors	6	$49,680	$298,080	
Field Supervisors	1	$54,450	$54,450	
Total Positions	14			
Subtotal			$590,130	
Fringe Costs (29%)			$171,138	
Total salary and fringe				**$761,268**
Supplies and Expenses		$300,000	$300,000	
Equipment		$40,000	$40,000	
Contract inspectors compensation	58	$80,000	$4,640,000	
Indirect costs (19.4%)			$487,186	
Total Supplies and Expenses				**$5,467,186**
FY07 Expenditures				**$6,228,454**

REVENUES

Public, Commercial, and Industrial Inspection Fee	**Inspection Fee**

Number of Fixture Units	
25 or less	$300
26 to 50	$900
51 to 150	$1,200
151 to 249	$1,500
250 or more	$1,800
Call back fee (each visit)	$100
Residential Inspection Fee	$50
Call back fee (each visit)	$50

- Inspection fees for commercial and public projects may be collected with submitted plans once the legislation takes effect at the start of the program in FY06. We assume associated fees could be collected in full from the start of the effective date of the legislation, although it will take some time both to inform plumbing contractors of the new inspection requirements and to hire additional inspectors to carry out the inspections. Number per year and average fee, based on the size of the projects, could vary considerably.
- It is likely that the program for providing a license to currently unlicensed plumbers will take some time to implement. Unlicensed plumbers must apply for a restricted plumbing contractors license by January 1, 2006. Therefore this source of funding will not reach full estimated revenue until FY07. 100% FY 2007 forward)
- It is likely that the program for residential plumbing installations and associated fees will take up to 4 years to implement as people become aware of the requirements, so revenues from this source are prorated accordingly.
- The revenues for the inspector certification program will begin once the program for certification begins, and so that should reach full funding in the first fiscal year after the legislation becomes effective.

New Fees	Number	Fee	FY 2006 Total	FY 2007 Total	FY 2008 Total	FY 2009 Total
New Restricted Plumbing Contractor license	5,000	$90	$225,000	$450,000	$450,000	$450,000
Inspector certification exam fee	1,000	$50	$25,000	$50,000	$50,000	$50,000
New Public, Commercial, Industrial Inspection fee	2,850	$975	$1,389,375	$2,778,750	$2,778,750	$2,778,750
New Residential Inspection fee – where code applies but no local program	60,060	$50	$1,001,000	$1,501,500	$2,252,250	$3,003,000
Total New Fees			**$2,640,375**	**$4,780,250**	**$5,531,000**	**$6,281,750**

Long-Term Fiscal Considerations

The expenditures associated with this bill will be funded by fees collected for providing these services. In this fiscal note the department has attempted to estimate the staffing and expenditures associated with the bill's requirements; nevertheless, due to the unknown amount of research activity required, it is possible that additional resources will be needed.

Local Government Costs
None

References/Sources
MPCA and MDH program staff. We were unable to consult with others or receive responses from our inquiries before the due date of this note.

Agency Contact Name: Randy Ellingboe (651-215-0838)
FN Coord Signature: MARGARET KELLY

Date: 03/31/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/04/05 Phone: 282-5065

Senator Higgins introduced--

S.F. No. 1706: Referred to the Committee on State and Local Government Operations.

A bill for an act

relating to human services; creating a task force to discuss collaboration between schools and mental health providers.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [TASK FORCE ON COLLABORATIVE SERVICES.]

The commissioner of the Department of Human Services, in collaboration with the commissioner of the Department of Education, shall create a task force to discuss collaboration between schools and mental health providers to: promote colocation and integrated services; identify barriers to collaboration; develop a model contract; and identify examples of where collaboration is successful. Members of the task force shall include representatives of school boards, administrative personnel, special education directors, counties, parent advocacy organizations, school social workers and psychologists, community mental health professionals, health plans, and other interested parties. The task force shall present a report to the chairs of the education and health policy committees by February 1, 2006.

Fiscal Note – 2005-06 Session

Bill #: S1706-0 **Complete Date:** 03/23/05

Chief Author: HIGGINS, LINDA

Title: SCHOOLS & MENTAL HEALTH PROVIDERS

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	40	0	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	40	0	0	0
Revenues					
General Fund	0	16	0	0	0
Net Cost <Savings>					
General Fund	0	24	0	0	0
Total Cost <Savings> to the State	0	24	0	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50			
Total FTE		0.50			

NARRATIVE: HF 1040

Bill Description

HF1040 requires the Department of Human Services, in collaboration with the Department of Education, to establish a task force on collaboration between schools and mental health providers. The task force must present a report to the legislature by February 1, 2006.

Assumptions

- The Department of Human Services will provide lead staffing for the task force, including recruitment of members, meeting planning and facilitation, research, preparation of the report, communications, and implementation planning.
- The task force is time-limited to fiscal year 2006, with most meetings occurring between August 2005 and February 2006.

Expenditure and/or Revenue Formula

General Fund	FY06	FY07	FY08	FY09
.5 FTE (salary and fringe)	27,000	0	0	0
Nonsalary costs	13,000	0	0	0
Total	40,000			
Admin Reimbursement (40% FFP)	16,000	0	0	0
Net Cost	24,000	0	0	0

Long-Term Fiscal Considerations

None – fiscal estimate assumes that task force is time-limited.

Local Government Costs

None

References/Sources

Glenace Edwall, 651-215-1382

Agency Contact Name: Glenace Edwall 215-1382
FN Coord Signature: STEVE BARTA
Date: 03/23/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/23/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S1706-0 **Complete Date:** 03/22/05

Chief Author: HIGGINS, LINDA

Title: SCHOOLS & MENTAL HEALTH PROVIDERS

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

The bill requires that the commissioner of human services in collaboration with the commissioner of education create a task force to discuss collaborations between schools and mental health providers to promote collaboration and integrated services, identify barriers to collaboration, develop a model contract and identify examples where collaboration is successful.

Assumptions

It is assumed that the commissioner of human services would take all responsibilities for setting up and running the task force.

The Department of Human Services' fiscal note will identify the fiscal impact of the bill. The Department of Human Services would be responsible for the final report.

It is assumed that the task force cost to MDE (primarily staff time) would be minimal.

Expenditure and/or Revenue Formula

None

Long-Term Fiscal Considerations

Limited time task force.

Local Government Costs

School districts and other service providers may incur additional staff costs for participating in the task force. It is assumed that these costs would be absorbed.

References/Sources

Agency Contact Name: Bulger, John 651-582-8781
FN Coord Signature: AUDREY BOMSTAD
Date: 03/22/05 Phone: 582-8793

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: BRIAN STEEVES
Date: 03/22/05 Phone: 296-8674

Senator ..... moves to amend S.F. No. 1837 as follows:

Page 22, lines 8 and 9, delete "amount being spent by the person as of September 30, 2004" and insert "daily average cost during calendar year 2004 or for persons who graduated from school during 2004, the average daily cost during July through December 2004, less one-half of case management and home modifications over $5,000"

Page 22, line 21, after "costs" insert "at the lowest rate available, considering daily, monthly, semiannual, annual, or membership rates"

Page 23, after line 19, insert:

"Sec. 34. [EXPIRATION DATE.]

Section 29 shall expire on the date the commissioner of human services implements a new consumer-directed community supports budget methodology that is based on reliable and accurate information about the services and supports intensity needs of persons using the option and that adequately accounts for the increased costs of adults who graduate from school and need services funded by the waiver during the day."

ADOPTED BY DIVISION 7/7/05

04/19/05 [COUNSEL] DG SCS1837A-7

Senator ..... moves to amend S.F. No. 1837 as follows:

Page 23, after line 15, insert:

"Sec. 33. [CONSUMER-DIRECTED COMMUNITY SUPPORTS WAIVER AMENDMENT REQUEST.]

(a) Recipients of home and community-based waiver services who are also residents of a foster home, as defined under Minnesota Rules, part 2960.3010, subpart 23, or of a family adult foster care home, as defined under Minnesota Statutes, section 144D.01, subdivision 7, shall be allowed to use the consumer-directed community supports waivered services option. In implementing this paragraph, the commissioner may, but is not required to, modify the federally approved consumer-directed community supports budget methodology.

(b) The commissioner of human services shall apply for a federal waiver amendment to implement paragraph (a).

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

A bill for an act

relating to human services; changing medical assistance, general assistance, and MinnesotaCare provisions to align with practice; allowing military enrollees and military families to reenroll at certain times; modifying the Consumer-Directed Community Supports methodology; establishing a clinical trial work group; amending Minnesota Statutes 2004, sections 256.045, subdivision 3a; 256B.02, subdivision 12; 256B.056, subdivisions 5, 5a, 5b, 7, by adding subdivisions; 256B.057, subdivision 1; 256B.69, subdivision 4; 256D.045; 256L.01, subdivisions 4, 5; 256L.03, subdivision 1b; 256L.04, subdivision 2, by adding subdivisions; 256L.05, subdivisions 3, 3a; 256L.07, subdivisions 1, 3, by adding a subdivision; 256L.15, subdivisions 2, 3; 549.02, by adding a subdivision; 549.04.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). ~~When a complaint is filed, the prepaid health plan must notify the ombudsman within three~~

~~working-days.~~ Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 2. Minnesota Statutes 2004, section 256B.02,

subdivision 12, is amended to read:

Subd. 12. [THIRD-PARTY PAYER.] "Third-party payer" means a person, entity, or agency or government program that has a probable obligation to pay all or part of the costs of a medical assistance recipient's health services. Third-party payer includes an entity under contract with the recipient to cover all or part of the recipient's medical costs.

Sec. 3. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 3d. [REDUCTION OF EXCESS ASSETS.] Assets in excess of the limits set forth in subdivisions 3 to 3c may be reduced to allowable limits as follows:

(a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by:

(1) designating burial funds up to $1500 for each applicant, spouse, and MA-eligible dependent child; and

(2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by:

(1) paying bills for health services that would otherwise be paid by medical assistance; and

(2) using any means other than a transfer of assets for less than fair market value as defined in section 256B.0595, subdivision 1, paragraph (b).

Sec. 4. Minnesota Statutes 2004, section 256B.056, subdivision 5, is amended to read:

Subd. 5. [EXCESS INCOME.] A person who has excess income is eligible for medical assistance if the person has expenses

for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the ~~20th~~ last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the ~~20th~~ last business day of the month in order to be eligible for this option in the following month.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 5. Minnesota Statutes 2004, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. [INDIVIDUALS ON FIXED OR EXCLUDED INCOME.] Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income ~~annually~~ every 12 months. The 12-month period begins with the month of application.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 6. Minnesota Statutes 2004, section 256B.056,

subdivision 5b, is amended to read:

Subd. 5b. [INDIVIDUALS WITH LOW INCOME.] Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income ~~on a semiannual basis~~ every six months. The six-month period begins the month of application.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 7. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read:

Subd. 7. [PERIOD OF ELIGIBILITY.] Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 8. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 9. [NOTICE.] The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the

person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

Sec. 9. Minnesota Statutes 2004, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. [INFANTS AND PREGNANT WOMEN.] (a)~~(1)~~ An infant less than one year of age is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than ~~200~~ 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of

income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except for the earned income disregard and employment deductions.

~~(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.~~

(b)(1) (Expired, 1Sp2003 c 14 art 12 s 19)

~~(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.~~

(c) ~~Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.~~ An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, that exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(d) An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

[EFFECTIVE DATE.] The amendments to paragraphs (a) and (b) are effective retroactively from July 1, 2004, and the amendment to paragraph (c) is effective retroactively from October 1, 2003.

Sec. 10. Minnesota Statutes 2004, section 256B.69, subdivision 4, is amended to read:

Subd. 4. [LIMITATION OF CHOICE.] (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee

Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in ~~an~~ non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15. Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the

health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Sec. 11. Minnesota Statutes 2004, section 256D.045, is amended to read:

256D.045 [SOCIAL SECURITY NUMBER REQUIRED.]

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 12. Minnesota Statutes 2004, section 256L.01, subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] (a)

"Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged.

(c) ~~Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease~~ "Gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 13. Minnesota Statutes 2004, section 256L.01, subdivision 5, is amended to read:

Subd. 5. [INCOME.] (a) "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income.

(b) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including,

but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 14. Minnesota Statutes 2004, section 256L.03, subdivision 1b, is amended to read:

Subd. 1b. [PREGNANT WOMEN; ELIGIBILITY FOR FULL MEDICAL ASSISTANCE SERVICES.] ~~Beginning January 1, 1999,~~ A pregnant woman ~~who is~~ enrolled in MinnesotaCare ~~when her pregnancy is diagnosed~~ is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date ~~the pregnancy is medically diagnosed~~ of conception. Co-payments totaling $30 or more, paid after the date ~~the pregnancy is diagnosed~~ of conception, shall be refunded.

Sec. 15. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 1a. [SOCIAL SECURITY NUMBER REQUIRED.] (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 16. Minnesota Statutes 2004, section 256L.04, subdivision 2, is amended to read:

Subd. 2. [COOPERATION IN ESTABLISHING THIRD-PARTY LIABILITY, PATERNITY, AND OTHER MEDICAL SUPPORT.] (a) To be eligible for MinnesotaCare, individuals and families must

cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

Sec. 17. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 2a. [APPLICATIONS FOR OTHER BENEFITS.] To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 18. Minnesota Statutes 2004, section 256L.05, subdivision 3, is amended to read:

Subd. 3. [EFFECTIVE DATE OF COVERAGE.] (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057,

coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the ~~date of entry into the family~~ month of placement. The effective date of coverage for other new ~~recipients~~ members added to the family ~~receiving covered health services~~ is the first day of the month following the month in which ~~eligibility is approved or at renewal, whichever the family receiving covered health services prefers~~ the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 19. Minnesota Statutes 2004, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. [RENEWAL OF ELIGIBILITY.] (a) Beginning January 1, 1999, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Beginning October 1, 2004, an enrollee's eligibility must be renewed every six months. The first six-month period of eligibility begins ~~in the month after~~ the month the application is approved received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 20. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner.

Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c)(1) Notwithstanding paragraph (b), families enrolled in MinnesotaCare under section 256L.04, subdivision 1, may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Families who are no longer eligible for MinnesotaCare under this subdivision shall be given an 18-month notice period from the date that ineligibility is determined before disenrollment. This clause expires February 1, 2004.

(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their ~~annual~~ gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds ~~$50,000~~ $25,000 for the six-month period of eligibility.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon HealthMatch implementation, whichever is later.

Sec. 21. Minnesota Statutes 2004, section 256L.07,

subdivision 3, is amended to read:

Subd. 3. [OTHER HEALTH COVERAGE.] (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, Medicare Part A or B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4, is considered health coverage. An applicant or enrollee may not refuse Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance or

general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) ~~Effective October 1, 2003, applicants who were recipients of medical assistance and had~~ Cost-effective health insurance ~~which~~ that was paid for by medical assistance ~~are exempt from~~ is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

Sec. 22. Minnesota Statutes 2004, section 256L.07, is amended by adding a subdivision to read:

Subd. 5. [VOLUNTARY DISENROLLMENT FOR MEMBERS OF MILITARY.] Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18, shall apply to individuals and families enrolled under this subdivision upon six-month renewal.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 23. Minnesota Statutes 2004, section 256L.15, subdivision 2, is amended to read:

Subd. 2. [SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF MONTHLY GROSS INDIVIDUAL OR FAMILY INCOME.] (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding

fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

(b)(1) Enrolled families whose gross annual income increases above 275 percent of the federal poverty guideline shall pay the maximum premium. This clause expires effective February 1, 2004.

(2) Effective February 1, 2004, children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium.

(3) The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two

and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon implementation of HealthMatch, whichever is later.

Sec. 24. Minnesota Statutes 2004, section 256L.15, subdivision 3, is amended to read:

Subd. 3. [EXCEPTIONS TO SLIDING SCALE.] ~~An annual premium of $48 is required for all~~ Children in families with income at or ~~less than~~ below 150 percent of the federal poverty guidelines pay a monthly premium of $4.

[EFFECTIVE DATE.] This section is effective March 1, 2006, or upon implementation of HealthMatch, whichever is later.

Sec. 25. Minnesota Statutes 2004, section 549.02, is amended by adding a subdivision to read:

Subd. 3. [LIMITATION.] Notwithstanding subdivisions 1 and 2, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for costs to any prevailing defendant.

Sec. 26. Minnesota Statutes 2004, section 549.04, is amended to read:

549.04 [DISBURSEMENTS; TAXATION AND ALLOWANCE.]

Subdivision 1. [GENERALLY.] In every action in a district court, the prevailing party, including any public employee who prevails in an action for wrongfully denied or withheld employment benefits or rights, shall be allowed reasonable disbursements paid or incurred, including fees and mileage paid for service of process by the sheriff or by a private person.

Subd. 2. [LIMITATION.] Notwithstanding subdivision 1, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for disbursements to any prevailing defendant.

Sec. 27. [PLANNING PROCESS FOR MANAGED CARE.]

The commissioner of human services shall develop a planning

process for the purposes of implementing at least one additional managed care arrangement to provide medical assistance services, excluding continuing care services, to recipients enrolled in the medical assistance fee-for-service program, effective January 1, 2007. This planning process shall include an advisory committee composed of current fee-for-service consumers, consumer advocates, and providers, as well as representatives of health plans and other provider organizations qualified to provide basic health care services to persons with disabilities. The department shall seek any additional federal authority necessary to provide basic health care services through contracted managed care arrangements.

Sec. 28. [CLINICAL TRIAL WORK GROUP; REPORT.]

The commissioners of health and commerce shall, in consultation with the commissioner of employee relations, convene a work group regarding health plan coverage of routine care associated with clinical trials. The work group must explore what high-quality clinical trials beyond cancer-only clinical trials should be covered by health plans. All other types of clinical trials, disease-based or technology-based such as drug trials or device trials should be considered. The work group shall use the current, cancer-only model voluntary agreement that includes definitions of high-quality clinical trials, protocol induced costs, and routine care costs as a starting point for discussions. As determined appropriate, the work group shall establish model voluntary agreement guidelines for health plan coverage of routine patient care costs incurred by patients participating in high quality clinical trials. The work group shall be made up of representatives of consumers, patient advocates, health plan companies, fully insured and self-insured purchasers, providers, and other health care professionals involved in the care and treatment of patients. The commissioners shall submit the findings and recommendations of the work group to the chairs of the senate and house committees having jurisdiction over health policy and finance by January 15, 2006.

Sec. 29. [CONSUMER-DIRECTED COMMUNITY SUPPORTS METHODOLOGY.]

For persons using the home and community-based waiver for persons with developmental disabilities whose Consumer-Directed Community Supports budgets were reduced by the October 2004, state-set budget methodology, the commissioner of human services must allow exceptions to exceed the state-set budget formula up to the amount being spent by the person as of September 30, 2004, when the individual's county of financial responsibility determines that:

(1) necessary alternative services will cost the same or more than the person's current budget; and

(2) administrative expenses or provider rates will result in less hours of needed staffing for the person than under the Consumer-Directed Community Supports option. Any exceptions the county grants must be within the county's allowable aggregate amount for the home and community-based waiver for persons with developmental disabilities.

Sec. 30. [COSTS ASSOCIATED WITH PHYSICAL ACTIVITIES.]

The expenses allowed for adults under the Consumer-Directed Community Supports option shall include costs, including transportation, associated with physical exercise or other physical activities to maintain or improve the person's health and functioning.

Sec. 31. [WAIVER AMENDMENT.]

The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services consistent with sections 29 and 30 by August 1, 2005.

Sec. 32. [INDEPENDENT EVALUATION AND REVIEW OF UNALLOWABLE ITEMS.]

The commissioner of human services shall include in the independent evaluation of the Consumer-Directed Community Supports option provided through the home and community-based services waivers for persons with disabilities under 65 years of age:

(1) provision for ongoing, regular participation by

stakeholder representatives through June 30, 2007;

(2) recommendations on whether changes to the unallowable items should be made to meet the health, safety, or welfare needs of participants in the Consumer-Directed Community Supports option within the allowed budget amounts. The recommendations on allowable items shall be provided to the senate and house of representatives committees with jurisdiction over human services policy and finance issues by January 15, 2006; and

(3) a review of the statewide caseload changes for the disability waiver programs for persons under 65 years of age that occurred since the state-set budget methodology implementation on October 1, 2004, and recommendations on the fiscal impact of the budget methodology on use of the Consumer-Directed Community Supports option.

Sec. 33. [EFFECTIVE DATE.]

Sections 29 and 30 are effective upon federal approval of the waiver amendment in section 31. Sections 31 and 32 are effective the day following final enactment.

Minnesota Department of **Human Services**

Memo

DATE: April 19, 2005

TO: **Senator Becky Lourey**
Health and Human Services Budget Division

FROM: Jan Taylor, Manager
Benefit Recovery Section
651.296.6964 651.296.9438 (FAX)

SUBJECT: Informal Fiscal Information Related to Proposed Amendment to SF 1837

Per Senator Berglin's request and our conversation today, I am providing information about the possible effect of removing sections 25 and 26 from SF 1837.

The Department proposed this language because we are now required to be an independent party to legal actions initiated by a Medical Assistance recipient to recover medical expenses due to an injury. The potential exists that we could be required to pay costs and disbursements of a prevailing defendant in a district court action. Since all of the recoveries that are made in successful claims are paid to the General Fund (and to the Federal agency based on FFP), any such amount assessed to DHS must be paid from our administrative budget. The dollar limit on payment of costs is $200.00 in a district court case and $300.00 in an appeal. Since there is no dollar limit on **disbursements** that might be made to defend a case (depositions, expert witnesses, including physicians, etc.), it is the unknown "potential cost" that we are concerned about. We don't know the number of cases that may be affected by this provision, but since the possibility exists, even a small number of cases could have a fiscal impact.

DHS had not been a plaintiff party to the action prior to the MN Supreme Court case (Martin v. City of Rochester). In the past, plaintiffs who are receiving medical assistance have not had the resources and been looked to for payment of defendants' costs. We believe that the number of cases and associated costs would escalate with just one case where DHS is required to pay.

Assumptions: Average costs & disbursements: $10,000 per case

For these reasons, we estimate the following costs if this amendment is adopted (state funds).

FY 2006	FY 2007	FY2008	FY2009
$20,000 (4 cases)	$25,000 (5 cases)	$30,000 (6 cases)	$35,000 (7 cases)

Cc: David Godfrey, Senate Fiscal Analysis

Oral Healthcare Solutions Project
Planning Partners List

Professional Organizations

- Minnesota Dental Association
- Minnesota Dental Hygienists' Association
- Minnesota Dental Assistants' Association
- Minnesota Association for Community Dentistry
- Minnesota Primary Care Association

Community Clinics and Safety Net Providers

- Apple Tree Dental
- Children's Dental Services
- Community University Health Care Center
- Family Health Care Center
- Peterson and Peterson Family Dental
- Red River Valley Dental Access Project
- West Side Community Health Services

Educational Programs

- Century College
- Lake Superior Community College
- Mankato State University
- Minneapolis Community & Technical College
- Normandale Community College
- University of Minnesota, Department of Pediatrics
- University of Minnesota, School of Dentistry

Head Start and Community Action Programs

- Minnesota Head Start Association
- Community Action, Duluth
- Mahube Community Action, Detroit Lakes
- Ramsey Action Programs Head Start
- Western Community Action Head Start

Health Plans

- HealthPartners
- PrimeWest Health System

Advocacy and Local Public Health

- Carver County
- Dakota County
- Legal Services Advocacy Project
- Minneapolis Department of Health and Family Support
- Minnesota Disability Law Center
- Oral Health America Foundation
- Region Nine Development Commission
- Renville County

State Agencies

- Minnesota Department of Human Services
- Minnesota Department of Health
- Minnesota Board of Dentistry
- Minnesota Center for Rural Health, Rural Health Resource Center

Others

- Cincinnatus
- MAP for Nonprofits
- Project Management Institute
- OMNII Oral Pharmaceuticals
- Mount Olivet Rolling Acres

And numerous additional local individuals and national experts!

Minnesota Oral Healthcare System
Pilot Project Overview

Background

Disparities in oral health status and access to dental care are a major problem in Minnesota and across the country. Minnesota is experiencing a significant decline in its dentist to population ratio and it is becoming increasingly difficult for public program patients to obtain needed care. In addition, many dentists' experiences with the administrative burdens and low reimbursement levels of Minnesota's Health Care Programs have led them to reduce or stop seeing public program patients. Many of Minnesota's 660,000 public program patients have poorer oral health, face language and transportation barriers, and have been unable to obtain routine dental care causing them to seek treatment for dental emergencies in emergency rooms and urgent care centers. These complex needs are not being met by the current payment and delivery system.

The Oral Healthcare Solutions Project

Minnesota's Department of Human Services (DHS) recognized that the current system is not effective in delivering dental care to public program patients, and awarded a planning grant to Apple Tree Dental to facilitate the design of a new Oral Healthcare System model to serve Minnesota's public program patients. The new model was designed in collaboration with over fifty partnering organizations and individuals and culminates many years of effort. To implement and evaluate the newly designed Oral Healthcare System model, a two-year Pilot Project was created.

Working with local Minnesota stakeholders with support from national experts, the Oral Healthcare Solutions Project developed a new Oral Healthcare System model featuring patient-centered, evidence-based strategies that will expand access and enhance the delivery of oral healthcare services to people of all ages enrolled in Minnesota's Health Care Programs (MHCP).

Features of the new Oral Healthcare System model include:

- The earliest possible prevention, screening, diagnosis, and treatment
- New points of entry for patients at community sites like Head Start centers and schools
- An expanded workforce with new roles for allied health professionals
- New roles for private dentists and safety net clinics to work together in new ways
- A new care coordination system that matches patients with community resources
- Evidenced-based care and new systems that lead to better outcomes and accountability

Cost Saving Strategies:

1. **Provide less costly education, prevention and screening services**

Community Oral Healthcare Sites can deliver education, prevention and screening services on-site at a lower cost than private dental offices. Data shows that between 55 and 90% of children below poverty are healthy and do not need to see a dentist. Screening larger numbers of patients early, and doing so at a much lower cost at Community Oral Healthcare Sites, reallocates existing funding to permit higher payments to dentists for examinations and restorative services.

2. **Optimize the roles of all the providers:**
   - **Private Practices**
   - **Oral Health Centers**
   - **Community sites**
   - **Emergency Rooms**

The roles of Private Practices are optimized by triaging patients after they have been educated, screened and have received a "respectful referral" for a successful dental visit, reducing appointment failures. The roles of the old "safety net" clinics change from providing high levels of expensive care for people with uncontrolled dental disease, to the coordinators of a public health approach that targets preventive care to at-risk people through community site partnerships. Emergency room use for urgent dental care needs can be virtually eliminated in the new model by using the Help Center to coordinate effective and timely dental visits.

3. **Optimize the frequency of preventive care, based on risk assessment**

Substantial costs can be saved in the new model by tailoring the frequency of oral screenings and dental examinations to the needs of each patient. Patients who have been disease free for one or more years, and are at low risk for disease can be seen annually rather than every six months. Conversely, patients who are actively experiencing disease, or who have moderate or high risk factors should be seen more frequently for preventive services and screenings.

4. **Reduce the use of ineffective treatments**

The new model will reduce the use of ineffective treatments by collecting centralized data and using a Clinical Advisory Board to apply principles of evidence-based care and disease management to optimize the use of the most effective treatments and minimize the use of ineffective treatments.

5. **Reduce indirect costs**

Indirect costs include those for claims processing, as well as costs incurred by the general health care system due to failures of the oral health system. Administrative costs are reduced in the new model by eliminating multiple redundant administrative systems. General healthcare savings can be obtained by reducing the consequences of untreated dental diseases which include low birth weight pre-term babies, pneumonia, heart disease, oral cancer, and complications of diabetes.

Pilot Project Budget Overview:

Local, national and international data clearly demonstrates that dental diseases can be prevented in the vast majority of the population, and the need for costly dental care can be dramatically reduced by moving from a surgical to a public health model for the delivery of oral healthcare. The new Oral Healthcare System Pilot Project puts these lessons learned into action, and creates a model that will reduce dental disease and per person costs for MHCP recipients over time.

Startup Budget:

The Pilot Project isn't simply a new administrative strategy. It represents the creation of a new delivery system, and will incur one-time Startup Costs including:

- Establish on-site oral health services at Community Oral Healthcare Sites. This will require that Oral Healthcare Centers receive startup grants to hire and train teams of dental hygienists, dental assistants and dentists, acquire new mobile dental equipment, trucks for transportation, and new portable computers and software systems to collect and transmit screening information.
- Recruit private dentists, design new provider agreements, establish reimbursement schedules, and computerize new "Dental Practice Profiles".
- Establish a Help Center with a "1-800" call center, and an integrated web site. Recruit and train center staff members with expertise in both social services and group dental practice support.
- Establish a new type of interdisciplinary Management Group, hiring key staff and developing partnership agreements between involved organizations.

The Pilot Project is expected to serve between 60,000 and 80,000 MHCP enrollees. The Pilot Project's Startup Budget is estimated to total between $2 million and $3 million and will be paid for with a lead grant of $2 million from DHS, along with in-kind contributions of over 50 partnering organizations and additional financial resources provided by other public and private sources including foundations and corporations. The Pilot Project will be a true public/private partnership.

Operating Budget:

The Pilot Project's operating budget will be paid for using existing DHS funding streams that will be reallocated to the Pilot Project by "carving out" the current dental benefits of a limited pool of MHCP recipients in three regions of the state, and redirecting those benefits to the Pilot Project. MHCP recipients will continue to be enrolled in their PMAP or the Fee-For-Service systems for their other health benefits. The "carve out of dental benefits" plan for the Pilot Project is very similar to previously carried out "carve outs" that have been based on the "county" within which the enrollee resides. However, instead of carving out MHCP enrollees by "county", the new Pilot Project carves them out by their "dental provider." Enrollment of dental providers and subsequent enrollment of their MHCP patients into the new Oral Healthcare System would continue to grow during repeated quarterly enrollment periods until the total number of enrollees reaches a maximum size specified by DHS for this Pilot Project. The total operating budget would be scaled and adjusted to cover the costs for serving the patients included in the Pilot Project. Throughout the two years of the Pilot Project, comprehensive data collection and analysis will be used to assess the effectiveness of the project in reaching its goals.

The new Oral Healthcare System will:

1. **Establish a single point of contact for patients and providers**

A new **Help Center** will be established to serve as a single point of contact for both patients and providers. The Help Center offers "1-800" and "web" based customer services that coordinate mutually "respectful referrals" between patients and dentists. In addition to coordinating dental appointments, the new Help Center also monitors access to care and collects information needed for quality assurance and program evaluation.

2. **Enhance the roles of private dentists and safety net clinics**

Private dentists are offered flexible roles that respect their individuality, simplify their participation and enhance their reimbursements. Private dentists complete their own custom dental practice profiles which enable the Help Center to control the type and number of public program patients "respectfully referred" to each private dentist each month.

Safety-net clinics become "**Oral Healthcare Centers**" in the new model. These centers employ dental hygienists to work at community sites like Head Start centers and schools. The centers are also able to coordinate care with private dental practices in collaboration with the Help Center.

3. **Increase the number of community sites offering oral health services**

At convenient new "**Community Oral Healthcare Sites**", dental hygienists will collaborate with teachers, nurses and Head Start staff to make it possible for at-risk patients to gain access to the earliest possible prevention, screening, diagnosis, and treatment. Community-based care is a cost-effective way to promptly detect and refer patients and avoid costly emergency room visits.

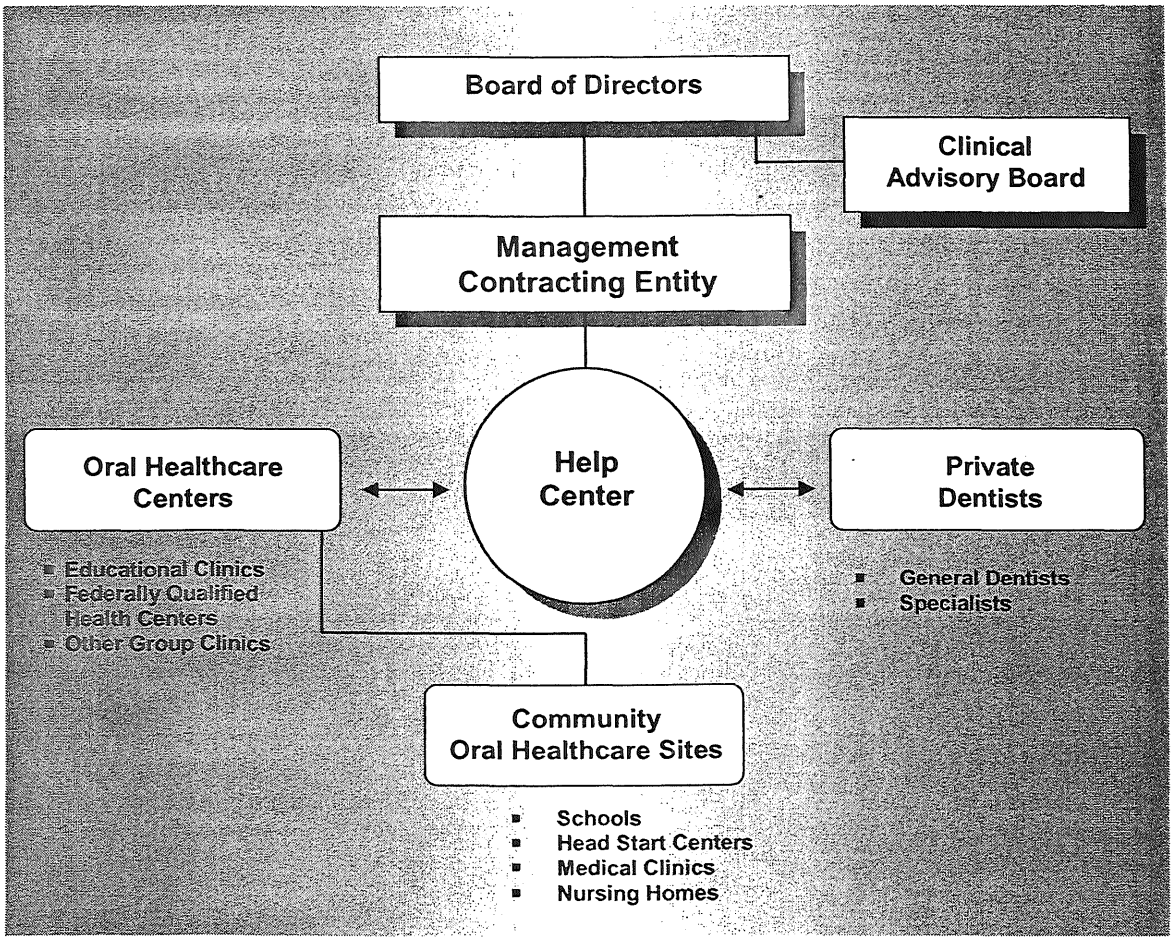
4. **Expand the oral healthcare workforce**

The new Oral Healthcare System expands the oral healthcare workforce using the existing supply of dentists, and the expanding supply of dental hygienists. Using "collaborative agreements" between dentists and hygienists, education and prevention services can be provided to at-risk MHCP recipients at "Community Oral Healthcare Sites" conveniently and cost effectively.

By deploying hygienists to screen and triage patients based on their needs, "respectful referrals" can be made to private dental offices and safety net clinics making best use of these limited dental care resources.

Oral Healthcare System Diagram

The diagram below illustrates the key roles played in the new Oral Healthcare System. A Management Contracting Entity (MCE) will be selected via an RFP and implementation contract awarded by DHS to carry out the Pilot Project. The MCE will be governed by a Board of Directors and will establish a Clinical Advisory Board to provide advice on leading practices, evidence-based care and other clinical issues.



Help Center

The Help Center is a critical new component of the Oral Healthcare System model. The Help Center will be staffed by care coordinators skilled at helping MHCP patients coordinate transportation, language and other social services needed to obtain dental care successfully. In addition, Help Center staff must be familiar with the scheduling and billing needs of dental practices, oral healthcare centers, and community oral healthcare sites. The Help Center will use information management technologies to create a single point of contact for clients and providers and to respectfully match patient and provider needs and community resources. This single

source of system-wide information will also provide centralized data for quality assurance and evaluation.

Private Dental Practices

Increasing the participation of Private Dental Practices is another key ingredient for a successful new system. Private Dentists will have enhanced flexibility and control over how they participate and will receive higher reimbursements from a single administrator. Private Dental Practices can choose whether to provide comprehensive dental services for public program patients or to deliver specific treatments recommended by a referring Oral Healthcare Center or via a Help Center referral. Private dentists will be able to control the type and number of public program patients referred to them on a monthly basis by updating their Dental Practice Profiles.

Oral Healthcare Centers

Existing safety net clinics such as Federally Qualified Health Centers, the School of Dentistry and Critical Access Dental Providers can become "**Oral Healthcare Centers**" in the new model. In addition to providing their current safety-net dental services, the new Oral Healthcare Centers will expand or establish on-site services agreements with Community Oral Health Sites and employ hygienists in collaborative agreements to provide education, prevention, and screening. The Oral Healthcare Centers will also provide diagnosis and referral services, collect high quality diagnostic information, develop treatment plans, and collaborate with private dental practices to provide necessary restorative care.

Community Oral Healthcare Sites

Community Oral Healthcare Sites play a critical role in expanding access to services by providing convenient new points of entry for public program patients. These sites will offer oral health education, prevention and screening services without the need for transportation to private dental offices, and offer the help of teachers, nurses and translators to overcome cultural barriers. Community Oral Healthcare Sites establish contracts with Oral Healthcare Centers or private practice dentists who will employ dental hygienists to provide services on-site.

Management Contracting Entity

A single organization, called the Management Contracting Entity (MCE), will be responsible for developing and implementing the Oral Healthcare System Pilot Project. The MCE will establish a Board of Directors, which will include key stakeholders such as the University of Minnesota School of Dentistry, the Minnesota Dental Association, the Minnesota Primary Care Association, the Minnesota Dental Hygienists' Association, and advocacy group representatives along with Pilot Project partners. The purpose of the Board of Directors is to provide governance oversight for the Oral Healthcare Pilot Project. The Board of Directors will receive clinical decision-making advice from a Clinical Advisory Board that will apply evidence based care principles. The Clinical Advisory Board's members will include both local and national experts in clinical oral healthcare.

The Management Contracting Entity will consist of partners and staff with expertise in the areas needed to manage the pilot project. The MCE will be responsible for Pilot Project enrollment, finance, information systems, Help Center management, quality assurance, marketing, communications, and evaluation.

ATTACHMENT "B"

04/20/05 [COUNSEL] KC SCS1837A-8

Senator ..... moves to amend S.F. No. 1837 as follows:

Page 21, after line 12, insert:

"Sec. 28. [ORAL HEALTH CARE SYSTEM PILOT PROJECT START-UP GRANT.]

The commissioner of human services shall issue a request for proposal for a two-year pilot project that shall provide dental services for Minnesota health care program recipients through a new oral health care delivery system. The request for proposal shall be based upon the model designed by the Oral HealthCare Solutions Project. The proposal must demonstrate the capacity to obtain broad community support and to leverage the state's start-up funding by attracting additional public and private funding. The pilot project must include both urban and rural regions of the state, and adhere to the financial and delivery system requirements specified by the commissioner in accordance with the Oral HealthCare Solutions Project design."

Page 23, after line 15, insert:

"Sec. 33. [APPROPRIATION.]

$150,000 in fiscal year 2006 is appropriated from the state government special revenue fund to the commissioner of human services for start-up funds to develop and operate a model oral health care pilot project."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Berglin introduced--

S.F. No. 109: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying the provider tax paid by federally qualified health centers and rural health clinics; appropriating money.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINICS GRANTS.]

The commissioner of human services shall provide grants to federally qualified health centers and rural health clinics equal to the percentage of the provider tax imposed under Minnesota Statutes, section 295.50 to 295.59, for the previous calendar year multiplied by the payments made to each health clinic in the previous calendar year for medical assistance and MinnesotaCare recipients who are eligible for federal matching funds. The grants shall be distributed by April 15 of each year beginning April 15, 2005.

Sec. 2. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2005, for the purposes of section 1.

Fiscal Note – 2005-06 Session

Bill #: S0109-0 **Complete Date:** 03/07/05

Chief Author: BERGLIN, LINDA

Title: HEALTH CTRS & RURAL HEALTH GRANTS

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 109/HF 652

Bill Description

Effective January 1, 2004, a law change applied the MinnesotaCare 2% tax to the MA and MinnesotaCare revenues of providers. At the same time, the MA and MinnesotaCare rates were increased 2% for all providers affected by the tax change, with exception of FQHCs and RHCs. These rates were not increased because it was believed that the payment could not exceed the federally required PPS rate. This bill is intended to offset the tax by providing grants to FQHCs instead of a rate increase. Recently, it has been determined that the rate increase can be accomplished through a state plan amendment.

Assumptions

A cost cannot be attached to SF109. Federal regulations governing health care provider specific taxes prohibits states from making non-Medicaid payments (grants) to providers/taxpayers that are positively correlated to the amount of the tax, and any payment that guarantees to hold harmless for all or a portion of the tax. 42 CFR 433.68 (f)(1) and (3). The penalty for an unallowable provider tax would be a reduction in Minnesota's federal grant funding under Medicaid, equal to the half the value of the provider tax as applied to all providers.

Expenditure and/or Revenue Formula

NA : DO NOT INTERPRET ABOVE ASSUMPTIONS AS $0.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Paul Olson 296-5620
FN Coord Signature: STEVE BARTA
Date: 03/03/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/07/05 Phone: 282-5065

A bill for an act

relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; modifying utilization review provisions; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 62M.06, subdivisions 2, 3; 144.1501, subdivisions 2, 4; 256.045, subdivision 3a; 256.9693; 256B.0625, subdivision 3b, by adding a subdivision; 256B.0627, subdivisions 1, 4, 9; 256B.0631, by adding a subdivision; 256D.03, subdivision 4; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes

of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of

providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) Notwithstanding paragraphs (a) to (g), the rates must not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62D.12, subdivision 19, is amended to read:

Subd. 19. [COVERAGE OF SERVICE.] A health maintenance organization may not deny or limit coverage of a service which

the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision does not apply to health maintenance organizations for services provided in the prepaid health programs administered under chapter 256B, 256D, or 256L.

Sec. 3. Minnesota Statutes 2004, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major

disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company" has the meaning given in section 62J.041.

(g) For coverage that is provided by a health plan company under the terms of a contract with the Department of Employee Relations, the commissioner of employee relations shall direct the contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 4. Minnesota Statutes 2004, section 62J.04, subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals and premium growth limits;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to

achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal <u>and premium growth limit</u> data available to the public in a consumer-oriented manner.

Sec. 5. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM HEALTH PLAN COMPANY COST-CONTAINMENT GOALS~~ HEALTH CARE EXPENDITURE LIMITS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01 and also includes employee health plans offered by self-insured employers.

(c) "~~Total~~ Health care expenditures" means incurred claims or expenditures on health care services~~, administrative expenses, charitable contributions, and all other payments~~ made by health plan companies ~~out of premium revenues~~.

~~(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.~~

~~(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota Comprehensive Health Association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the Health Coverage Reinsurance Association, assessments by the Minnesota Life and Health Insurance Guaranty Association, assessments by the Minnesota Risk Adjustment Association, and any new assessments imposed by federal or state law.~~

~~(f)~~ "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost containment goals~~ health care expenditure limits for ~~the increase in net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost containment goal~~ health care expenditure limit.

The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health plan companies shall submit to the commissioner of health, by April ~~1, 1994, for calendar year 1993, April 1, 1995, for calendar year 1994, April 1, 1996, for calendar year 1995, April 1, 1997, for calendar year 1996, and April 1, 1998, for calendar year 1997~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, health care expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. ~~The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the~~

~~commissioner.~~

Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the cost containment goals. No premium rate, currently reviewed by the Department of Health or Commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end

of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment-goal~~ health care expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost-containment-goal,~~ health care expenditure limit at least 30 days before publishing the list, and shall provide each health plan company ~~with~~ ten days to provide an explanation for exceeding the ~~cost-containment-goal~~ health care expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Sec. 6. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

(d) This section does not apply to health plan companies offering only limited dental or vision plans.

Sec. 7. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium growth limit compliance;

(4) conduct applied research using existing and new data

and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

Sec. 8. Minnesota Statutes 2004, section 62J.38, is amended to read:

62J.38 [COST CONTAINMENT DATA FROM GROUP PURCHASERS.]

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for

nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made

during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 9. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 10. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

(b) Notwithstanding paragraph (a), the rates shall not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the~~

~~growth-rate-applied-under-section-62J.04,-subdivision-1,~~
~~paragraph-(b),-to-calendar-year-1994.~~

Sec. 11. Minnesota Statutes 2004, section 62M.06, subdivision 2, is amended to read:

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 12. Minnesota Statutes 2004, section 62M.06, subdivision 3, is amended to read:

Subd. 3. [STANDARD APPEAL.] The utilization review

organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(c) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the physician must follow publicly available evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

(e) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Sec. 13. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 14. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

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

(2) for midlevel practitioners agreeing to practice in designated rural areas~~,~~; and

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions.

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

Sec. 15. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that ~~75~~ 50 percent of the funds available are used for rural physician loan forgiveness ~~and~~, 25 percent of the funds available are used for underserved urban communities loan forgiveness, and 25 percent of the funds available are used for pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant

meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 16. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days. Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the

recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. <u>The referee may not overturn a decision by a prepaid health plan to deny or limit coverage for services if the prepaid health plan has used evidence-based criteria or guidelines in making the determination.</u> The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 17. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured

health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBLE PERSONS.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the

applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under

subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section; to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than

funds appropriated plus the drug rebate proceeds.

Sec. 18. Minnesota Statutes 2004, section 256.9693, is amended to read:

256.9693 [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance or general assistance medical care may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

Sec. 19. Minnesota Statutes 2004, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] Medical assistance

covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation, unless the communication is between a pediatrician and psychiatrist for the purpose of managing the medications of a child with mental health needs. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Sec. 20. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D and 256L, effective for services provided on or after July 1, 2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall

solicit comments and recommendations from any interested persons and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 21. Minnesota Statutes 2004, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have

never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party. Assessments shall not be conducted by the same agency, individual, or organization providing the care services.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be

delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures

specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties <u>who are parents of minors or guardians of minors or incapacitated persons</u> may delegate the responsibility to another adult ~~who is not the personal care assistant~~ <u>during a temporary absence of at least</u>

24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 22. Minnesota Statutes 2004, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18). For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after

insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in

order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

~~(11)~~ (12) home maintenance or chore services;

~~(12)~~ (13) services not specified under paragraph (a); and

~~(13)~~ (14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services.

Sec. 23. Minnesota Statutes 2004, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. [FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total

amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not exceed before the end date; and

(3) how actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must ensure that the month-to-month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 24. Minnesota Statutes 2004, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. [HEALTHY LIFESTYLE WAIVER.] The co-payments described in subdivision 1 shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

Sec. 25. [256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT PAYMENT SYSTEM.]

(a) The commissioner of human services shall establish a performance reporting and payment system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L.

(b) The measures used for the performance reporting and payment system for medical groups or single-physician practices shall include, but are not limited to, measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting and payment system for inpatient hospitals shall include, but are not limited to, measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the

case of a medical group or single-physician practice, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to develop the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) For recipients seen on or after January 1, 2007, the commissioner shall provide a performance bonus payment to providers who have achieved certain levels of performance established by the commissioner with respect to the measures or who have achieved certain rates of improvement established by the commissioner with respect to the measures or whose rates of achievement have increased over a previous period, as established by the commissioner. The performance bonus payment may be a fixed dollar amount per patient, paid quarterly or annually, or alternatively payment may be made as a percentage increase over payments allowed elsewhere in statute for the recipients identified in paragraph (a). In order for providers to be eligible for a performance bonus payment under this section, the commissioner may require the providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may contract with a reporting organization to assist with the collection of reporting information and to prevent duplication of reporting. The commissioner may limit application of the performance bonus payment system to providers that provide a sufficiently large

volume of care to permit adequate statistical precision in the measurement of that care, as established by the commissioner, after consulting with other health care quality reporting organizations.

(d) The performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

(e) The commissioner shall publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year, at least three months prior to the beginning of that calendar year.

(f) By April 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical group, single-physician practice, and hospital of the measures and the performance payments under this section, and shall compare the results by medical group, single-physician practice, and hospital for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may contract with a health care reporting organization that operates a Web site suitable for this purpose.

Sec. 26. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including

home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received, including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under

section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 27. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in

section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the

hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has

reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) The co-payments described in paragraph (d) shall be waived by the provider if the recipient practices a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except

inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 28. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income

of a family or individual exceeds program income limits.

(c) ~~(1)~~ Notwithstanding paragraph (b), individuals and families ~~enrolled in MinnesotaCare under section 256L.04, subdivision 1,~~ may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given ~~an 18-month~~ a 12-month notice period from the date that ineligibility is determined before disenrollment. ~~This clause expires February 1, 2004.~~

~~(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment.~~ The premium for ~~children~~ individuals and families remaining eligible under this ~~clause~~ paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

Sec. 29. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at

least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with

income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 30. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the services described in subdivision 2.

(b) Prior authorization shall be conducted by the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director and medical policy director in place, the commissioner may contract prior authorization to a Minnesota-licensed utilization review organization.

(c) This subdivision expires July 1, 2007, or when a list is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) positive emission tomography (PET) scans;

(2) electronic beam computed tomography (EBCT);

(3) virtual colonoscopy;

(4) spinal fusion, unless in an emergency situation related to trauma;

(5) bariatric surgery;

(6) chiropractic visits beyond ten visits;

(7) circumcision; and

(8) orthodontia.

Subd. 3. [SERVICES REQUIRING REVIEW BEFORE ADDITION TO PUBLIC PROGRAMS BENEFIT SETS.] No new medical device, brand drug, or medical procedure shall be included in the medical assistance benefit set until a technology assessment has been completed and the potential benefits are proven to outweigh the

additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations.

Sec. 31. [TASK FORCE ON CHILDHOOD OBESITY.]

(a) The commissioner of health, in consultation with the commissioners of human services and education, shall convene a task force to study and make recommendations on reducing the rate of obesity among the children in Minnesota. The task force shall determine the number of children who are currently obese and set a goal, including measurable outcomes for the state in terms of reducing the rate of childhood obesity. The task force shall make recommendations on how to achieve this goal, including, but not limited to, increasing physical activities; exploring opportunities to promote physical education and healthy eating programs; improving the nutritional offerings through breakfast and lunch menus; and evaluating the availability and choice of nutritional products offered in public schools. The members of the task force shall include representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public Health Association of Minnesota; the Minnesota Dietetic Association; the Minnesota School Food Service Association; the Minnesota Association of Health, Physical Education, Recreation, and Dance; the Minnesota School Boards Association; the Minnesota School Administrators Association; the Minnesota Secondary Principals Association; the vending industry; and consumers. The terms and compensation of the members of the task force shall be in accordance with Minnesota Statutes, section 15.059, subdivision 6.

(b) The commissioner must submit the recommendations of the task force to the legislature by January 15, 2007.

Sec. 32. [IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS SYSTEM.]

The commissioner of health, in consultation with the electronic health record planning work group established in Laws

2004, chapter 288, article 7, section 7, shall develop a statewide plan for all hospitals and physician group practices to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the commissioner shall consider:

(1) creating financial assistance to hospitals and providers for implementing or updating an electronic health records system, including, but not limited to, the establishment of grants, financial incentives, or low-interest loans;

(2) addressing specific needs and concerns of safety-net hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an electronic records system within the hospital or practice; and

(3) providing assistance in the development of possible alliances or collaborations among providers.

The commissioner shall provide preliminary reports to the chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 2007, on the status of reaching the goal for all hospitals and physician group practices to have an interoperable electronic health records system in place by January 1, 2005. The reports shall include recommendations on statutory language necessary to implement the plan, including possible financing options.

Sec. 33. [APPROPRIATION.]

(a) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;

(2) support practical nursing programs in regions of high need;

(3) address the shortage of nursing faculty; and

(4) provide accessible learning opportunities to students through distance education and simulation experiences.

(b) $..... is appropriated for the biennium beginning

July 1, 2005, from the general fund to the commissioner of health for the loan forgiveness program in Minnesota Statutes, section 144.1501.

ADOPTED BY DIVISION - 4/18/05

Senator ..... moves to amend S.F. No. 65 as follows:

Page 5, delete lines 17 to 22 and insert:

"(g) A health plan company may reduce reimbursement to providers in order to meet the premium growth limitations required by this section."

Page 7, lines 6 and 7, delete the new language and insert "This definition does not include the state employee health plan offered under chapter 43A"

Page 17, line 17, after "provider" insert "conducting the review" and after "follow" insert "coverage policies adopted by the health plan company that are based upon"

Page 17, line 19, after "organization" insert ", a nationally recognized guideline development organization,"

Page 18, line 27, after "physician" insert "conducting the review" and after "follow" insert "coverage policies adopted by the health plan company that are based upon"

Page 18, line 29, after "organization" insert ", a nationally recognized guideline development organization,"

Page 22, line 15, after "used" insert "coverage policies adopted by the health plan company that are based upon published"

Page 22, line 17, after "determination" insert "unless the recipient can show by clear and convincing evidence that the determination should be overturned"

Page 27, delete section 18

Page 28, after line 16, insert:

"Sec. 19. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25a. [PRIOR AUTHORIZATION FOR CERTAIN SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the services described in paragraph (c) for reimbursement under this chapter, chapters 256D, and 256L. Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in paragraph (c) unless the prepaid health plan is otherwise using evidence-based practices to address these services.

(b) Prior authorization shall be conducted by the medical

director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director or medical policy advisory council in place, the commissioner shall contract prior authorization to a Minnesota-licensed utilization review organization.

(c) The following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) chiropractic visits beyond ten visits;

(5) circumcision; and

(6) orthodontia.

(d) No new medical device, brand drug, or medical procedure shall be included in the benefit sets under this chapter, chapter 256D, or 256L until a technology assessment has been completed and the potential benefits are proven to outweigh the additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations."

Page 30, line 13, after the period, insert "A new eligibility certification form must be signed by the recipient's attending physician and the recipient every time a new face-to-face assessment or service update is made."

Page 30, line 20, delete the new language

Page 30, delete lines 21 and 22

Page 30, line 36, after "(e)" insert "Eligibility certification form" means a document based on the assessment,

approved by the commissioner, signed by the recipient's attending physician and the recipient, that describes:

(1) the specific type of personal care assistant services that are to be provided;

(2) the specific amount, in hours and number of days, of personal care assistant services that are to be provided; and

(3) the length of time, not to exceed 12 months, that the personal care assistant services are to be provided.

(f)"

Page 31, line 3, strike "(f)" and insert "(g)"

Page 31, line 12, strike "(g)" and insert "(h)"

Page 31, line 17, strike "(h)" and insert "(i)"

Page 31, line 19, strike "(i)" and insert "(j)"

Page 31, line 35, strike "and"

Page 31, line 36, after "(6)" insert "maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7)"

Page 32, line 2, strike "(j)" and insert "(k)"

Page 32, line 22, after "requirements" insert "; the organization must maintain documentation to ensure that the personal care assistant has complied with the requirements of section 256B.0627, subdivision 1, paragraph (j), clause (6), and the organization must:

(i) obtain the recipient's attending physician's signature on the eligibility form; and

(ii) obtain the recipient's signature on the eligibility certification form"

Page 32, line 23, strike "(k)" and insert "(l)"

Page 32, lines 35 and 36, reinstate the stricken "who is not the personal care assistant"

Page 33, line 5, after the period, insert "The delegated responsible party is not required to reside with the recipient while serving as the responsible party if adequate supervision and monitoring are provided for as part of the person's

individual service plan under a home- and community-based waiver program or in conjunction with a home care targeted case management service provider or other case manager."

Page 33, line 17, strike "(l)" and insert "(m)"

Page 33, line 27, strike "(m)" and insert "(n)"

Page 34, line 5, strike "(n)" and insert "(o)"

Page 34, line 19, after the period, insert "To be eligible for payment, these services must not exceed the service guidelines and dollar limits in the personal care limit decision tree as required by this section."

Page 34, line 23, after "amount" insert ", length," and after "authorized" insert "by the recipient's attending physician in the eligibility certification form"

Page 36, line 24, after "criteria" insert "which is documented with substantiating financial documentation" and after "and" insert "upon review of this documentation"

Page 37, line 6, strike "and"

Page 37, line 8, before the period, insert "; and

(15) services not certified by the recipient's attending physician in an eligibility certification form"

Page 37, line 24, after the period, insert "The audit process must include, at a minimum, a requirement that (1) each personal care assistant be assigned an identification number; (2) each bill submitted by an agency or individual must include the identification numbers of each personal care assistant providing services to the client; and (3) the documentation of hours of care provided must include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified. The commissioner shall use an eligibility certification form signed by the recipient's attending physician and the recipient that certifies that the recipient requires personal care assistant services. The eligibility certification form shall contain a penalty notice indicating that any person who obtains certification by misrepresentation or fraud shall be guilty of a misdemeanor.

(g) The commissioner shall maintain a personal care limit decision tree that sets forth the maximum number of hours that may be applied to a particular type of personal care assistant service. The commissioner shall establish guidelines for each type of personal care assistant service based on need and dependency. In order to be eligible for payment, adherence to the service and dollar limitations by the personal care provider organization and personal care assistant shall be required beginning July 1, 2005. Any county public health nurse or certified public health nurse under contract with the county or with a prepaid health plan who conducts assessments for personal care assistant services shall follow these guidelines."

Page 37, strike lines 33 to 35 and insert "Authorized services must be used within a calendar month and shall not be carried over to the following month. If rolling eligibility is reinstated under chapter 256B, flexible use hours may be used over a six-month period."

Page 38, lines 8 to 27 delete the new language

Page 38, line 28, delete "(d)"

Page 39, line 1, delete "(e)" and insert "(c)"

Page 39, line 4, delete "(f)" and insert "(d)"

Page 48, after line 7, insert:

"(p) Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in section 256B.0625, subdivision 25a, unless the prepaid health plan is otherwise using evidence-based practices to address these services.

Sec. 28. [256L.036] [PRIOR AUTHORIZATION OF SERVICES.]

Effective July 1, 2005, prepaid health plans shall use prior authorization for the services described in section 256B.0625, subdivision 25a, unless the prepaid health plan is otherwise using evidence-based practices to address these services."

Page 53, line 36, delete everything before "established" and insert "Health Information Technology and Infrastructure Advisory Committee"

Page 54, line 21, delete "2005" and insert "2015"

Page 54, after line 23, insert:

"Sec. 34. [TRAINING REQUIRED.]

Effective July 1, 2005, the commissioner of human services shall develop a plan for increased training of physicians, public health nurses, personal care assistants, and enrollees or persons acting as responsible parties who are interested in hiring a personal care assistant under the self-directed option:

(1) training for physicians shall include information on the personal care assistant benefit, the requirements for participation and the guidelines for services developed by the commissioner;

(2) training for public health nurses shall include ensuring that level of need determinations and guidelines for services as developed by the commissioner are understood and consistently applied;

(3) training for personal care assistants, particularly nonagency employed personal care assistants, should include which services are appropriate for a personal care assistant to provide. A personal care assistant shall attend at least four hours of training annually; and

(4) training for those interested in hiring a personal care assistant under the self-directed option should be conducted by a nurse and include how to employ a personal care assistant, what services are appropriate for a personal care assistant, and what responsibilities are included in managing a personal care assistant.

Training must begin no later than October 1, 2005.

Sec. 35. [RATE REDUCTION.]

(a) Effective for the services identified in Minnesota Statutes, section 256B.0625, subdivision 25a, paragraph (c), rendered on or after July 1, 2005, the payment rate shall be reduced by ... percent from the rate in effect on June 30, 2005.

(b) This section shall expire on June 30, 2006, or upon the completion of the prior authorization system required under Minnesota Statutes, section 256B.0625, subdivision 25a,

paragraph (b), whichever is later."

Page 54, delete lines 25 to 35

Page 54, line 36, delete "(b)"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Fiscal Note Request Worksheet

Bill #: SF 65 Title: Health Care Cost Containment Omnibus
Companion #: 153 Author: Berglin Agency: Human Services
Urgent: Due Date: Committee:
Consolidated: Lead Agency: Contact Person: Char Sadlak 651-296-5599

What version of the bill are you working on? 3 A
(Changing the version of the bill will automatically create a new fiscal note request.)

(The following four fiscal impact questions must be answered before an agency can sign off on a fiscal note.)

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Fund-General		5,155	(2,711)	(3,439)	(3,860)
Fund-HCAF		1,382	8,704	11,863	12,980
Fund					
Less Agency Can Absorb					
Fund					
Fund					
Fund					
Net Expenditures					
Fund-General		5,155	(2,711)	(3,439)	(3,860)
Fund-HCAF		1,382	8,704	11,863	12,980
Fund					
Revenues					
Fund-General		731	744	642	680
Fund-HCAF		132	299	219	196
Fund					
Net Cost <Savings>					
Fund-General		4,424	(3,455)	(4,081)	(4,540)
Fund-HCAF		1,250	8,405	11,644	12,784
Fund					
Total Cost <Savings> to the State		5,674	4,950	7,563	8,244

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents					
Fund-General		11.00	15.00	14.00	15.00
Fund-HCAF		5.00	10.00	8.00	7.00
Fund					
Total FTE		16.00	25.00	22.00	22.00

Bill Description

Section 8- Cost Containment Data from Group Purchasers.
Requires the cost containment data to be broken down to distinguish between the individual market, the small group market, and the large group market.

Section 11- Expedited Appeal.
States that for review of initial determinations not to certify a service for prepaid health care programs under Medical assistance, general assistance medical care, or Minnesotacare, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

Section 12- Standard Appeal.
States that for review of initial determinations not to certify a service for prepaid health care programs under Medical assistance, general assistance medical care, or Minnesotacare, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

Section 13- Coverage Exemptions.
States that notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46. [see section 20]

Section 16- Prepaid Health Plan Appeals.
States that on appeal, the referee may not overturn a decision by a prepaid health plan to deny or limit coverage for services if the prepaid health plan has used evidence-based criteria or guidelines in making the determination.

Section 17 - Prescription Drug Discount Program.
Establishes the prescription drug discount program. Requires the commissioner administer a drug rebate program to finance. Establishes eligibility criteria. Requires a one-page application form. Sets out application procedures, processing timelines, an annual enrollment fee, annual redeterminations. Requires the commissioner pay a switch fee to pharmacies. Establishes a dedicated fund for the program, and requires the commissioner administer the program so that costs do not exceed appropriations plus rebates.

Section 18 - Continuing care program for persons with mental illness expansion.
Requires the expansion of the current MA psychiatric contract bed benefit to include GAMC effective 7/1/05. However, 1/1/06 is the earliest date by which necessary contract amendments could occur.
(section deleted in A-10 amendment)

Section 19 – Telemedicine Consultations.
Amends MS § 256B.0625, subd. 3b. To expand the scope of telemedicine consultations to allow pediatricians and psychiatrists to bill for telephone only consultations with each other

Section 20 - List of Excluded Services.
This section requires the department to biennially create a list of services excluded from coverage. Allows the commissioner to appoint an ad hoc advisory panel to assist in reviewing and establishing the list. Identifies considerations to be used in establishing the list. Requires the commissioner to solicit comments and recommendations and conduct at least one public hearing. Requires the establishment of the list by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even numbered years beginning October 1, 2008, for the lists effective the following July 1. The list must be published on November 1 of even-numbered years, and submitted to the legislature by January 15 of the odd-numbered years.

Section 21 - Home Care Assessments.
Requires home care assessments to be conducted by an agency or organization that is not the provider of care services; and establishes additional criteria for the delegation of duties for responsible parties for personal care services during temporary absences.

Section 22 - Prior Authorization Personal Care Services.

Establishes a prior authorization for hardship waivers and defines criteria for waivers; requires the commissioner to establish an ongoing audit process for potential fraud and abuse for personal care services.

Section 23 - Flexible Use of Personal Care Assistant Hours.
Makes flexible use of PCA service optional; requires the public health nurse to develop a written month to month plan of the projected use of personal care services; requires the provider to incorporate the month to month plan into the care plan; allows the recipient, responsible party, or commissioner to revoke the authorization for flexible use of PCA hours.

Section 24 – Health Lifestyle Waiver
MA co-payments shall be waived by the provider if the person refrains form tobacco use or is participating in a smoking cessation program This would require federal approval.

Section 25- Performance Reporting & Quality Improvement Payment System
Requires the Commissioner to establish a performance reporting and payment system for providers who provide services to public program recipients.

Section 26 – Employee Scholarship.
This section provides a rate increase of two-tenths of one percent to a variety of home and community-based providers, ICFs/MR, and DT&H settings to be used for employee scholarships. It requires that providers who receive a rate increase of at least $1,000 per year report certain data on use of the scholarship funding to the commissioner. The commissioner must seek and collect the data, analyze it, and create and distribute an annual report to the legislature. The bill does not require the commissioner to enforce the expenditure of these funds for scholarships. Therefore, this fiscal note does not include enforcement costs.

Section 27 – GAMC Co-payments
GAMC copays are waived if the person does not smoke or is participating in a smoking cessation program

Section 28 – Restores MinnesotaCare MCHA Exception.
Restores the Minnesota Comprehensive Health Association (MCHA) exception to all MinnesotaCare enrollees whose income increases to exceed the applicable standard and provides a 12-month notice period. Individuals and families may remain enrolled if 10 percent of their annual income is less than the premium for a policy through MCHA with a $500 deductible. Enrollees who become ineligible due to income above the standard are given a 12-month notice period before coverage ends. Currently, the MCHA exception applies only to children under age 21, and children who lose eligibility under the exception receive a 12-month notice period prior to disenrollment.

Section 29 - MinnesotaCare Small Employer Option.
Adds a MinnesotaCare coverage option for small employers. Eligible employers include businesses that employ 2-50 eligible employees, the majority of whom are employed in Minnesota, and municipalities with 50 or fewer employees. Eligible employees are those who work at least 20 hours per week and more than 26 weeks annually. See worksheets for additional details and assumptions.

Section 30 - Limiting Coverage of Health Care Services
Lists a number of services that will require prior authorization for reimbursement in the public program effective July 1, 2005. This section also requires that a technology assessment be conducted by an independent organization before any new medical device, brand drug, or medical procedure is included in the covered services for public programs.

Section 31- Child Obesity Task Force
Requires a task force to study and make recommendations on reducing the rate of obesity among children in Minnesota.

Fiscal Summary

Fiscal Summary
SF 65 3A
2005 Session

Fund	Description	Section	FY06	FY07	FY08	FY09
General	HealthMatch Costs	Various	3,734	0	0	0
General	MMIS Costs	8	3	0	0	0
General	MMIS Costs	17	155	0	0	0
General	FTE Costs	17	134	79	0	0
General	FTE and Admin. Costs	17	146	638	638	733
General	PDDP Costs	17	0	430	217	(120)
General	MMIS Costs	19	2	0	0	0
General	MA Costs	19	15	52	65	65
General	Total Costs	New-19	(903)	(2,505)	(2,633)	(2,637)
General	MMIS Costs	20	22	0	0	0
General	Tech. Eval. Contract Costs	20	100	100	100	100
General	FTE Costs	21	70	70	70	70
General	MA Costs	21	231	242	256	270
General	FTE Costs	22	140	140	140	140
General	FTE Costs	23	70	70	70	70
General	MA Costs	23	947	994	1,052	1,106
General	MA Costs	23	692	727	769	809
General	MA Costs	21-23	(4,794)	(10,247)	(11,022)	(11,783)
General	MA Costs	21-23	1,438	3,074	3,306	3,535
General	Admin. Costs	21-23	250	0	0	0
General	MMIS Costs	26	7	0	0	0
General	Admin. Costs	26	35	35	35	35
General	MA Costs	26	1,848	2,394	2,576	2,761
General	MMIS Costs	27	10	0	0	0
General	GAMC Costs	27	307	767	872	936
General	MMIS Costs	29	112	0	0	0
General	FTE Costs	29	134	79	0	0
General	Admin. Costs	34	250	150	50	50
GENERAL FUND TOTAL COSTS			5,155	(2,711)	(3,439)	(3,860)
HCAF	MnCare Costs	New-19	(265)	(447)	(385)	(376)
HCAF	Admin.	28	33	54	42	43
HCAF	MnCare Costs	28	728	1,851	1,875	1,934
HCAF	Admin.	29	297	694	506	447
HCAF	MnCare Costs	29	589	6,552	9,825	10,932
HCAF TOTAL COSTS			1,382	8,704	11,863	12,980
General	FFP from FTEs	17	53	31	0	0
General	FFP from FTEs and admin.	17	58	255	255	293
General	FFP from Admin.	New-19	201	201	201	201
General	FFP from Tech. Eval. Contract	20	40	40	40	40
General	FFP from FTE	21	28	28	28	28
General	FFP from FTE	22	56	56	56	56
General	FFP from FTE	23	28	28	28	28
General	FFP from Admin.	21-23	100	0	0	0
General	FFP from Admin.	26	14	14	14	14
General	FFP from FTE	29	53	31	0	0
General	FFP from Admin.	34	100	60	20	20
TOTAL GF REVENUE			731	744	642	680
HCAF	FFP from Admin.	28	13	22	17	17
HCAF	FFP from Admin.	29	119	277	202	179
TOTAL HCAF REVENUE			132	299	219	196

General	FTE	17	1.50	1.00	0.00	0.00
General	FTE	17	4.00	9.00	10.00	11.00
General	FTE	21	1.00	1.00	1.00	1.00
General	FTE	22	2.00	2.00	2.00	2.00
General	FTE	23	1.00	1.00	1.00	1.00
General	FTE	29	1.50	1.00	0.00	0.00
TOTAL GENERAL FUND FTE			11.00	15.00	14.00	15.00
HCAF	FTE	28	1.00	1.00	1.00	1.00
HCAF	FTEs	29	4.00	9.00	7.00	6.00
TOTAL HCAF FTE			5.00	10.00	8.00	7.00

Assumptions

The complex design of the innovative HealthMatch system is near completion and programming has begun. Due to the intricacies of programming a new system, any change prior to system completion requires substantial analysis and design rework, in addition to programming the actual changes. This effort delays the HealthMatch implementation date and results in costs of $889,000 per month of delay. Currently, for each month of delay to the project, the associated vendor cost for maintaining staff on the project is $600,000. Concurrent state staff costs per month are $289,000. (Numbers reflect 100% of the cost; state budget costs are less when adjusted for federal participation) The proposed provisions of this bill, in the aggregate, would result in a 16 month HealthMatch delay.

Once HealthMatch is completely built and implemented, the cost for making requested changes will be significantly lower. Legislation with effective dates of August 1, 2006, or upon HealthMatch implementation, whichever is later, will not incur the state staff and associated vendor costs caused by implementation delay, although they will, as with current systems, require investments of time for analysis and design. For instance, these provisions in the aggregate would take an estimated 12 months to incorporate in a post-HealthMatch implementation phase at a total cost of $1,800,000
(state share would be 35% of the total)

See attached worksheets.

Fiscal Worksheets

A section by section cost for HealthMatch is not available. We have estimated HealthMatch costs based on the aggregate costs for this bill.

HealthMatch costs	10,668,000
State share, HealthMatch costs (35%)	3,733,800

Section 8- Cost Containment Data from Group Purchasers.

	FY2006	FY2007	FY2008	FY2009
MMIS costs	7,200	0	0	0
Federal Share	4,680	0	0	0
State Share (GF)	2,520	0	0	0
GF impact	2,520	0	0	0

Section 11- Expedited Appeal
No fiscal impact

Section 12- Standard Appeal
No fiscal impact

Section 13- Coverage Exemptions
No fiscal impact

Section 16- Prepaid Health Plan Appeals
No fiscal impact

Section 17 - Prescription Drug Discount Program

HealthMatch impact

	FY2006	FY2007	FY2008	FY2009
MMIS costs	442,200	0	0	0
Federal Share	287,430	0	0	0
State Share (GF)	154,770	0	0	0

Other Admin Costs

Policy and program development, and training needs (costs include salary, fringe, and overhead). 1 FTE needed for developing policy, implementing program and policy for drug discount, and .5 FTE needed for County training

	FY2006	FY2007	FY2008	FY2009
	1.5	1	0	0
FTE costs--GF	133,500	78,500	0	0
FFP @ 40%	53,400	31,400	0	0

Prescription Drug Discount Program. Staff needed for enrollment administration. Costs prorated for FY2006

	FY2006	FY2007	FY2008	FY2009
FTE needed	4	9	10	11
Costs for FTE	141,000	587,708	587,860	682,712
Costs for postage and printing	5,000	50,000	50,000	50,000
Total Costs-General Fund	146,000	637,708	637,860	732,712
FFP @ 40%	58,400	255,083	255,144	293,085

Program Costs

No age limit, DHS administers eligibility, no asset test, no income limit, people enrolled in Medicare not eligible
Enrollment fees rather than having admin costs taken out of rebate

Estimates the cost to the state to advance rebate revenues to pharmacies for discounted drugs provided to individuals without prescription drug coverage. Rebate revenues are billed and received by DHS up to 4 months after the end of a quarter. We assume that 90% of revenue for a quarter is received by the end of the next quarter.

	Total Population	Population Under 250% FPG
Minnesota population	4,919,000	
Assume 16% lack prescription drug coverage	787,000	

Number with Medicare lacking prescription drug coverage, assuming 90% of these are under 250% FPG	257,200	231,480
Number without Medicare lacking prescription drug coverage, assuming 80% of these are under 250% FPG	529,800	423,840
Assume 57% of those with Medicare have drug costs at least $250/yr	146,604	131,944
Assume 5% of those w/o Medicare have drug costs at least $250/yr	26,490	21,192
Assume no enrollment by those with Medicare	0	0
Assume 50% enrollment by those without Medicare	13,245	10,596
Total enrollment by second quarter of CY 2008	13,245	10,596
Assume program participants with Medicare will have 36 Rx per year	36	36
Assume program participants w/o Medicare will have 24 Rx per year	24	24
Weighted average Rx per year	24	24
Weighted average Rx per quarter	6	6

Projected avg rebate per Rx	$11.78
Offsets to discount per Rx retained by DHS:	
to repay cash-flow cost to Gen. Fund in 7 years:	$0.53
for DHS admin. costs:	$0.00
Total retained by DHS per Rx	$0.53
Offset to discount for switch fee:	$0.17
Net rebate per Rx to consumer:	$11.09

Enrollment and Cost Projections

CY 2006	Q1	Q2	Q3	Q4
Enrollment	0	0	2,119	3,709
Prescriptions	0	0	12,715	22,252
Rebate Payments	$0	$0	$143,046	$250,331
Rebate Revenue			$0	$134,807
Quarterly Balance	$0	$0	($143,046)	($115,524)
Running Balance	$0	$0	($143,046)	($258,570)
CY 2007	Q1	Q2	Q3	Q4
Enrollment	5,033	6,358	7,417	8,477
Prescriptions	30,199	38,146	44,503	50,861
Rebate Payments	$339,734	$429,138	$500,661	$572,184
Rebate Revenue	$250,890	$346,378	$439,994	$516,758
Quarterly Balance	($88,844)	($82,760)	($60,667)	($55,426)
Running Balance	($347,414)	($430,174)	($490,842)	($546,267)

CY 2008	Q1	Q2	Q3	Q4
Enrollment	9,536	10,596	10,622	10,649
Prescriptions	57,218	63,576	63,735	63,894
Rebate Payments	$643,707	$715,230	$717,018	$718,811
Rebate Revenue	$591,651	$666,543	$741,436	$750,610
Quarterly Balance	($52,056)	($48,687)	$24,418	$31,800
Running Balance	($598,323)	($647,010)	($622,592)	($590,792)

CY 2009	Q1	Q2	Q3	Q4
Enrollment	10,676	10,702	10,729	10,756
Prescriptions	64,054	64,214	64,375	64,536
Rebate Payments	$720,608	$722,409	$724,215	$726,026
Rebate Revenue	$752,487	$754,368	$756,254	$758,145
Quarterly Balance	$31,879	$31,959	$32,039	$32,119
Running Balance	($558,913)	($526,954)	($494,915)	($462,796)

CY 2010	Q1	Q2	Q3	Q4
Enrollment	10,783	10,810	10,837	10,864
Prescriptions	64,697	64,859	65,021	65,183
Rebate Payments	$727,841	$729,660	$731,485	$733,313
Rebate Revenue	$760,040	$761,940	$763,845	$765,755
Quarterly Balance	$32,199	$32,280	$32,360	$32,441
Running Balance	($430,597)	($398,317)	($365,957)	($333,515)

CY 2011	Q1	Q2	Q3	Q4
Enrollment	10,891	10,918	10,946	10,973
Prescriptions	65,346	65,510	65,673	65,838
Rebate Payments	$735,147	$736,984	$738,827	$740,674
Rebate Revenue	$767,669	$769,588	$771,512	$773,441
Quarterly Balance	$32,522	$32,604	$32,685	$32,767
Running Balance	($300,993)	($268,389)	($235,704)	($202,937)

CY 2012	Q1	Q2	Q3	Q4
Enrollment	11,000	11,028	11,055	11,083
Prescriptions	66,002	66,167	66,333	66,499
Rebate Payments	$742,526	$744,382	$746,243	$748,108
Rebate Revenue	$775,374	$777,313	$779,256	$781,204
Quarterly Balance	$32,849	$32,931	$33,013	$33,096
Running Balance	($170,088)	($137,157)	($104,144)	($71,048)

CY 2013	Q1	Q2	Q3	Q4
Enrollment	11,111	11,139	11,166	11,194
Prescriptions	66,665	66,831	66,999	67,166
Rebate Payments	$749,979	$751,854	$753,733	$755,618
Rebate Revenue	$783,157	$785,115	$787,078	$789,046
Quarterly Balance	$33,179	$33,262	$33,345	$33,428
Running Balance	($37,869)	($4,608)	$28,737	$62,165

Net funding needed	FY 2006	$0
Additional funding needed	FY 2007	$430,174
Additional funding needed	FY 2008	$216,835
Negative = Paid back to Gen. Fund	FY 2009	($120,056)
Negative = Paid back to Gen. Fund	FY 2010	($128,637)
Negative = Paid back to Gen. Fund	FY 2011	($129,928)
Negative = Paid back to Gen. Fund	FY 2012	($131,232)
Negative = Paid back to Gen. Fund	FY 2013	($132,549)
	Total	$4,608

Estimate of enrollment fee needed to cover administrative costs^

	FY 2006*	FY 2007	FY 2008	FY 2009	FY 2006 - 09
Summary of Admin Costs	$694,000	$783,000	$777,000	$777,000	$3,031,000
Average number of enrollees	0	4,305	9,007	10,662	7,991
			Annual enrollment fee	$126	
			Monthly enrollment fee	$11	

^Based on average of approx. 8000 enrollees per year FY 2007 - 2009 and $3,000,000 in admin costs for same period

The figures above represent projected cash-basis costs, by fiscal year, to advance the rebates.

	FY 2006	FY 2007	FY 2008	FY 2009
Section 17 Impact-- GF	$434,270	$1,146,382	$854,695	$612,656
Fed Reimbursement Offset (40%)	53,400	31,400	0	0

Rationale--section 17:

1) 4,919,000	Estimated Population of MN
2) 16%	Estimated percentage of Minnesotans without prescription coverage.
3) 5%	Percentage of people without Medicare and prescription drug coverage who spent more than $250 on prescriptions annually
4) 250% FPG limit	We assumed that this limit would reduce the total population estimate of Medicare enrollees lacking pharmacy coverage by 10% and the total non-Medicare population of people lacking pharmacy coverage by 20%.

Footnotes:

1) Items 1-2 are based on data from "Prescription Drug Coverage in Minnesota and the United States", Minnesota Dept. of Health, December 2000.
2) Item 3 is based on information form "Report to the President, Prescription Drug Coverage, Spending, Utilization and Prices", Federal Department of HHS, April 2000
3) The first engrossment differs from the original bill by shifting responsibility for enrolling participants from the counties to DHS. That increase DHS admin costs. Since DHS is to recover admin costs from rebates that are collected, this change effectively reduces the average discount per prescription received by participants.

Section 18 - Continuing care program for persons with mental illness expansion,
Section deleted in A-10 Amendment.

Section 19 – Telemedicine Consultations

	FY2006	FY2007	FY2008	FY2009
MMIS costs	4,800	0	0	0
Federal Share	3,120	0	0	0
State Share (GF)	1,680	0	0	0

2005 Session, Fiscal Analysis of SF-65, Section 19
Cost Estimate for Implementing Telemedicine Psychiatry Consultation Benefit for Children

Assumptions:

1) The psychiatry consultation benefit will be limited to psychiatrists who provide opinion / advice regarding the evaluation or management of a specific patient's problem or set of problems at the request of a primary care physician (general medicine, family practice, pediatrician, internal medicine).

2) The consulting psychiatrist will provide a written summary and recommendation of the consultation to the requesting physician.

3) Unlike current MA provisions, no face-to-face examination would be required, but the requesting physician would supply any necessary background information, verbally or by other means.

4) Since psychiatrists are in short supply, costs will be limited by their availability and offset in part by the costs of services they replace with consultation services.

Calculations:

Number of MHCP Enrolled Physicians listing a Psychiatry Specialty (August 2004)	78
Number estimated to be open to providing consultation as part of practice	10
Average amount of time per year available for consultation (4 hours per 49 weeks / year)	196
Estimated hours of consultation provided once implemented	1960

Rate Info for Consultation Services

CPT	Description	Minutes	Rate	$/minute	Est % of Charges	Weighted per minute
99241	Outpt Consult - str forward 1	15	46.35	3.09	23.75%	0.73
99242	Outpt Consult - str forward 2	30	60.25	2.01	33.25%	0.67
99243	Outpt Consult - low complexity	40	78.79	1.97	23.75%	0.47

99244	Outpt Consult - mod complexity	60	113.55	1.89	9.50%	0.18
99245	Outpt Consult - high complexity	80	135.18	1.69	4.75%	0.08
99251	Inpt Consult - str forward 1	20	46.35	2.32	1.25%	0.03
99252	Inpt Consult - str forward 2	40	60.25	1.51	1.75%	0.03
99253	Inpt Consult - low complexity	55	78.79	1.43	1.25%	0.02
99254	Inpt Consult - mod complexity	80	113.55	1.42	0.50%	0.01
99255	Inpt Consult - high complexity	110	135.18	1.23	0.25%	0
					Estimated total cost per hour	132.77

Estimated total annual reimbursement for psychiatric consultation services 260,239

Discount for existing services replaced by demand for consultation services (50%) 130,119

Projected benefit costs (assume 1/1/06 start date and phase-in of implementation)

	FY 2006	FY 2007	FY 2008	FY 2009
Implementation Curve	60%	80%	100%	100%
Total Increased Service Cost	26,024	104,096	130,119	130,119
MA Families and Children	19,518	78,072	97,589	97,589
Federal Share	9,759	39,036	48,795	48,795
MA F&C State Share	9,759	39,036	48,795	48,795
MA Elderly and Disabled	6,506	26,024	32,530	32,530
Federal Share	3,253	13,012	16,265	16,265
MA E&D State Share	3,253	13,012	16,265	16,265
Secction 19 NET IMPACT GF	14,692	52,048	65,060	65,060

NEW Section 19--Limiting Coverage of Health Care Services

NOTE: paragraph (d) is not fiscal noted here. It cannot be implemented.

	FY2006	FY2007	FY2008	FY2009
MMIS costs	64,000	0	0	0
Federal Share	41,600	0	0	0
State Share (GF)	22,400	0	0	0

Other Admin
Adding Prior Authorization to certain services.

We currently authorize PET scans, EBCT, bariatric surgery and orthodontia - no savings/costs there.
Contract costs of $27.11 per review

ADMINISTRATIVE COSTS to adding to the Prior Authorization list:

	FY 2006	FY 2007	FY 2008	FY 2009
Spinal fusion				
MA	6,506	6,506	6,506	6,506
GAMC	813	813	813	813
Circumcision				
MA	82,062	82,062	82,062	82,062
GAMC	352	352	352	352
Chiropractic after 10 visits				
MA	47,009	47,009	47,009	47,009
GAMC	3,633	3,633	3,633	3,633
Nuclear Cardiology				
MA	61,350	61,350	61,350	61,350
GAMC	17,974	17,974	17,974	17,974
CT Scans				
MA	121,406	121,406	121,406	121,406
GAMC	26,459	26,459	26,459	26,459
MRI				
MA	108,575	108,575	108,575	108,575
GAMC	26,080	26,080	26,080	26,080
Consultant time				
75 X 4 hours	300	300	300	300
TOTALS				
MA	427,208	427,208	427,208	427,208
GAMC	75,311	75,311	75,311	75,311
GF IMPACT	502,519	502,519	502,519	502,519
Revenue-FFP Earned	201,008	201,008	201,008	201,008

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Prior-authorize Specific Services
Managed Care Effects
Senate File 65: 2E

Base Forecast

Managed Care Enrollment		FY 2006 (Average Enrollees)	FY 2007	FY 2008	FY 2009
Medical Assistance					
	Children and caretakers				
	Base	251,027	254,923	255,741	255,844
	HM shift	3,643	35,428	46,096	47,284
	Total	254,669	290,351	301,837	303,127
	Elderly	41,477	42,193	42,979	43,803

GAMC					
	Base: GA GAMC	6,068	6,169	6,213	6,224
	Base: GAMC-Only	19,891	20,344	20,426	20,202
	HM shift	911	8,942	11,808	12,250
	Total	26,870	35,455	38,448	38,676
MinnesotaCare					
	Parents and ch.	100,941	71,385	62,565	63,072
	PW and inf.	6,663	2,978	1,816	1,787
	Total fam. w children	107,604	74,363	64,381	64,859
	Adults < 75% FPG	14,519	6,430	3,892	3,868
	Adults > 75% FPG	18,106	17,118	16,156	14,807
	Total adults w no kids	32,625	23,547	20,048	18,676
Total enrollment		463,245	465,910	467,693	469,141
Projected Effects of Limits		FY 2006	FY 2007	FY 2008	FY 2009
Bariatric surgery					
	PMPM effect	-0.08	-0.08	-0.08	-0.08
	Cost effect	(185,298)	(447,273)	(448,986)	(450,376)
Chiropractic visits					
	PMPM	-0.05	-0.05	-0.05	-0.05
	Cost	(115,811)	(279,546)	(280,616)	(281,485)
Orthodontia					
	PMPM	-0.02	-0.02	-0.02	-0.02
	Cost	(46,324)	(111,818)	(112,246)	(112,594)
Spinal fusion					
	PMPM	-0.08	-0.08	-0.08	-0.08
	Cost	(185,298)	(447,273)	(448,986)	(450,376)
Radiology services					
	PMPM	-0.4	-0.4	-0.4	-0.4
	Cost	(926,490)	(2,236,367)	(2,244,928)	(2,251,878)
Personal care limits					
	PMPM	-0.2	-0.2	-0.2	-0.2
	Cost	(463,245)	(1,118,184)	(1,122,464)	(1,125,939)
Total cost effects		(1,922,466)	(4,640,462)	(4,658,225)	(4,672,646)
Allocation to budget activities		FY 2006	FY 2007	FY 2008	FY 2009
MA children & parents		(802,209)	(2,195,056)	(2,281,891)	(2,291,642)
	Federal share	(401,104)	(1,097,528)	(1,140,946)	(1,145,821)
	State share	(401,104)	(1,097,528)	(1,140,946)	(1,145,821)
MA elderly & disabled		(593,897)	(1,437,163)	(1,447,383)	(1,457,089)
	Federal share	(296,948)	(718,582)	(723,692)	(728,544)
	State share	(296,948)	(718,582)	(723,692)	(728,544)

GAMC		(84,641)	(268,041)	(290,665)	(292,393)
MinnesotaCare fam. w. children		(338,951)	(562,183)	(486,719)	(490,335)
	Federal share	(176,637)	(292,970)	(253,643)	(255,528)
		1	1	1	1
	State share	(162,314)	(269,213)	(233,076)	(234,807)
MinnesotaCare adults w no children		(102,768)	(178,019)	(151,566)	(141,187)

Managed Care Savings for Prior Authorization of circumcision

	Circumcision
MA FFS Expenditures	273,995
10% Prior Authorization	(27,400)
total costs	(27,400)
federal share	(13,700)
state share	(13,700)
MA Basic Care Managed Care costs	1,016,381,000
savings as a percent of costs (apply to managed care costs)	(0.000027)

	Circumcision
GAMC FFS Expenditures	5,014
10% Prior Authorization	(501)
total costs	(501)
federal share	0
state share	(501)
GAMC managed care costs	152,534,000
savings as a percent of costs (apply to managed care payments)	(0.000003)

MA F&C	FY 2006	FY 2007	FY 2008	FY 2009
manged care forecast	875,146,000	1,054,894,000	1,173,657,000	1,271,325,000
PA Circumcision	(23,592)	(28,438)	(31,639)	(34,272)
total costs	(23,592)	(28,438)	(31,639)	(34,272)
phase-in	(17,694)	(28,438)	(31,639)	(34,272)
federal share	(8,847)	(14,219)	(15,820)	(17,136)
state share	(8,847)	(14,219)	(15,820)	(17,136)
MA E&D				
manged care forecast	352,453,000	313,667,000	345,744,000	379,025,000
PA Circumcision	(9,501)	(8,456)	(9,321)	(10,218)
total costs	(9,501)	(8,456)	(9,321)	(10,218)
phase-in	(7,126)	(8,456)	(9,321)	(10,218)
federal share	(3,563)	(4,228)	(4,660)	(5,109)

state share	(3,563)	(4,228)	(4,660)	(5,109)
GAMC				
manged care forecast	187,847,000	251,760,000	292,833,000	317,003,000
PA Circumcision	(617)	(828)	(963)	(1,042)
total costs	(617)	(828)	(963)	(1,042)
phase-in	(463)	(828)	(963)	(1,042)
federal share	0	0	0	0
state share	(463)	(828)	(963)	(1,042)

SF 65 3A
2005 Session
New Section 19 (prior authorization for health care services)
Fiscal Worksheet

Assumptions:

We currently prior authorize PET scans, bariatric surgery and orthodontia, no savings there.
Payment data taken from CY2003.
Prior Authorizing will result in a 10% denial rate.
Fee for Service phase in is 9/12.

	Spinal Fusion	Circumcision	Chiropractic	Nuclear Cardiology	CT Scan	MRI
MA FFS Expenditures	2,993,770	273,995	517,576	1,810,000	3,572,000	3,540,000
10% Prior Authorization	(299,377)	(27,400)	(51,758)	(181,000)	(357,200)	(354,000)
total costs	(299,377)	(27,400)	(51,758)	(181,000)	(357,200)	(354,000)
federal share	(149,689)	(13,700)	(25,879)	(90,500)	(178,600)	(177,000)
state share	(149,689)	(13,700)	(25,879)	(90,500)	(178,600)	(177,000)
MA FFS outpatient costs	45,856,350	45,856,350	45,856,350	45,856,350	45,856,350	45,856,350
savings as a percent of costs (apply to FFS outpatient payments)	(0.0065)	(0.0006)	(0.0011)	(0.0039)	(0.0078)	(0.0077)

	Spinal Fusion	Circumcision	Chiropractic	Nuclear Cardiology	CT Scan	MRI
GAMC FFS Expenditures	448,442	5,014	40,937	506,000	781,000	850,000
10% Prior Authorization	(44,844)	(501)	(4,094)	(50,600)	(78,100)	(85,000)
total costs	(44,844)	(501)	(4,094)	(50,600)	(78,100)	(85,000)
federal share	0	0	0	0	0	0
state share	(44,844)	(501)	(4,094)	(50,600)	(78,100)	(85,000)
GAMC FFS outpatient costs	8,367,397	8,367,397	8,367,397	8,367,397	8,367,397	8,367,397
savings as a percent of costs (apply to FFS outpatient payments)	(0.0054)	(0.0001)	(0.0005)	(0.0060)	(0.0093)	(0.0102)

	FY 2006	FY 2007	FY 2008	FY 2009
MA F&C (FFS) outpatient hospital forecast	23,744,001	25,928,001	27,881,001	27,049,000

PA Spinal Fusion	(77,507)	(84,637)	(91,012)	(88,296)
PA Circumcision	(14,187)	(15,492)	(16,659)	(16,162)
PA Chiropractic	(13,400)	(14,632)	(15,735)	(15,265)
PA Nuclear Cardiology	(46,860)	(51,170)	(55,025)	(53,383)
PA CT Scan	(92,477)	(100,984)	(108,590)	(105,350)
PA MRI	(91,649)	(100,079)	(107,617)	(104,406)
total costs	(336,081)	(366,994)	(394,637)	(382,861)
phase-in	(252,061)	(366,994)	(394,637)	(382,861)
federal share	(126,030)	(183,497)	(197,319)	(191,431)
state share	(126,030)	(183,497)	(197,319)	(191,431)
MA E&D (FFS)				
outpatient hospital forecast	36,321,001	39,295,000	42,391,001	43,374,000
PA Spinal Fusion	(237,125)	(256,541)	(276,753)	(283,171)
PA Circumcision	0	0	0	0
PA Chiropractic	(40,995)	(44,352)	(47,846)	(48,956)
PA Nuclear Cardiology	(143,363)	(155,102)	(167,322)	(171,202)
PA CT Scan	(282,924)	(306,090)	(330,207)	(337,864)
PA MRI	(280,389)	(303,348)	(327,248)	(334,837)
total costs	(984,796)	(1,065,432)	(1,149,376)	(1,176,029)
phase-in	(738,597)	(1,065,432)	(1,149,376)	(1,176,029)
federal share	(369,299)	(532,716)	(574,688)	(588,014)
state share	(369,299)	(532,716)	(574,688)	(588,014)
GAMC (FFS)				
outpatient hospital forecast	5,808,001	5,963,000	5,911,000	5,398,001
PA Spinal Fusion	(31,127)	(31,958)	(31,679)	(28,930)
PA Circumcision	(348)	(357)	(354)	(323)
PA Chiropractic	(2,842)	(2,917)	(2,892)	(2,641)
PA Nuclear Cardiology	(35,123)	(36,060)	(35,745)	(32,643)
PA CT Scan	(54,211)	(55,658)	(55,172)	(50,384)
PA MRI	(59,000)	(60,575)	(60,047)	(54,835)
total costs	(182,651)	(187,525)	(185,890)	(169,757)
phase-in	(136,988)	(187,525)	(185,890)	(169,757)
federal share	0	0	0	0
state share	(136,988)	(187,525)	(185,890)	(169,757)

NEW Section 19 Summary:
(thousands of dollars)

Fund	Description	FY06	FY07	FY08	FY09
General	MMIS Costs	22	0	0	0
General	Admin.	503	503	503	503
General	MA-C&P	(401)	(1,098)	(1,141)	(1,146)
General	MA-E&D	(297)	(719)	(724)	(729)
General	GAMC	(85)	(268)	(291)	(293)
General	MA-F&C	(9)	(14)	(16)	(17)
General	MA-E&D	(4)	(4)	(5)	(5)
General	GAMC	0	(1)	(1)	(1)
General	MA-F&C	(126)	(183)	(197)	(191)
General	MA-E&D	(369)	(533)	(575)	(588)
General	GAMC	(137)	(188)	(186)	(170)
GF Totals		(903)	(2,505)	(2,633)	(2,637)

HCAF	MnCare-Fam w/Children	(162)	(269)	(233)	(235)
HCAF	MnCare w/o Children	(103)	(178)	(152)	(141)
HCAF Totals		(265)	(447)	(385)	(376)
General	Revenue-FFP	201	201	201	201

Section 20 - List of Excluded Services

	FY2006	FY2007	FY2008	FY2009
MMIS costs	64,000	0	0	0
Federal Share	41,600	0	0	0
State Share (GF)	22,400	0	0	0

It is not possible to predict savings on this section without a specific list of procedures and diagnostic code pairings. It should be noted that the Department was provided funding in FY03 to conduct a study to determine the appropriateness of eliminating reimbursement for certain payment codes. The costs listed below are necessary in addition to the funds appropriated in FY 03.

	FY2006	FY2007	FY2008	FY2009
HC Admin.-Tech. Eval. Contract-GF	100,000	100,000	100,000	100,000
Fed Reimbursement Offset (40%)	40,000	40,000	40,000	40,000

	FY2006	FY2007	FY2008	FY2009
Section 20 GF impact	122,400	100,000	100,000	100,000
Fed Reimbursement Offset (40%)	40,000	40,000	40,000	40,000

Section 21 Home Care Assesments

Admin Costs--section 21

Limits on delegation of Responsible Party
Administrative activities include consumer and provider training, training of public health nurses, monitoring implementation of policy to assure adherence. (1 FTE)

	FY06	FY07	FY08	FY09
FTE	1	1	1	1
Total GF Costs	70,000	70,000	70,000	70,000
Fed Reimbursement Offset (40%)	28,000	28,000	28,000	28,000

Program Costs-section 21
Requires detailed Physician certifcation for any update and Face to Face Assessment
90.00 per visit for 10% of adults and all children under 22

	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Average PCA Caseload	10,253	10,768	11,391	11,984
% Requiring multiple Assessment	50%	50%	50%	50%
Additonal Certifications	5,126	5,384	5,696	5,992

Cost/Certification	$ 90.00	$ 90.00	$ 90.00	$ 90.00
Total Costs	461,382	484,561	512,603	539,284
Federal Share	230,691	242,281	256,301	269,642
State Share	230,691	242,281	256,301	269,642

NOTE: Section 21 will also impact PCA services. See costs (savings) under section 23

Assumptions:

Responsible Party. This provision will limit the use of responsible party delegation for the PCA program. While this is estimated to affect about 250 persons, about 50-60 individuals would be affected for six months of the year(50% of their use) in terms of reduced use of PCA services. Other arrangements would need to be made by the family including institutional placement.

Section 22--Prior Authorization Personal Care Services

Requires prior authorization for hardship waivers

Administrative activities include authorizing hardship waivers, preparing for and attending appeals, consumer and provider training, education of public health nurses and monitoring and verifying compliance with criteria.

	FY2006	FY2007	FY2008	FY2009
FTEs	2	2	2	2
Total GF Costs	140,000	140,000	140,000	140,000
Fed Reimbursement Offset (40%)	56,000	56,000	56,000	56,000

NOTE: Section 21 will also impact PCA services. See costs (savings) under section 23

Assumptions:

Hardship Waivers. Based on previous request rates, 14% of the PCA recipients request hardship waivers, or about 1,500-1,600 per year. Of those requests, 20% are denied or about 300 per year. Of those denied, about half will experience a 50% reduction in PCA use due to lack of PCA providers.

Section 23--Flexible Use of Personal Care Assitant Hours

Additional Requirements for flexible use

Administrative activities include consumer and provider training, training of public health nurses, monitoring implementation of policy to assure adherence. (1 FTE)

	FY2006	FY2007	FY2008	FY2009
FTEs	1	1	1	1
Total GF Costs	70,000	70,000	70,000	70,000
Fed Reimbursement Offset (40%)	28,000	28,000	28,000	28,000

Program Costs--section 23

Increased Service Updates by Public Health Nurses for all children under age 22 and for 10% of adults 3 additional update/year on half of the average monthly caseload

	FY2006	FY2007	FY2008	FY2009
Average PCA Caseload	10,253	10,768	11,391	11,984
% Requiring multiple Assessment	50%	50%	50%	50%

Additional Assessment/Case	3	3	3	3
Number of reassessments	15,379	16,152	17,087	17,976
Cost/Reassessment	$ 123.10	$ 123.10	$ 123.10	$ 123.10
Total Costs	1,893,203	1,988,316	2,103,379	2,212,861
Federal	946,602	994,158	1,051,690	1,106,430
State	946,602	994,158	1,051,690	1,106,430

Increased Physician Certifications for all children under age 22 and for 10% of adults
1 additional update/year on half of the average monthly caseload

	FY2006	FY2007	FY2008	FY2009
Certification	15,379	16,152	17,087	17,976
Cost/Certification	$ 90.00	$ 90.00	$ 90.00	$ 90.00
Total Costs	1,384,145	1,453,683	1,537,808	1,617,851
Federal	692,073	726,842	768,904	808,926
State	692,073	726,842	768,904	808,926

SECTIONS 21-23
Effect on PCA Services reduced program use by 10% for non-waiver PCA recipients
Effect is delayed by 6 months in the first year

Estimated that 50% of non-waiver recipients would receive 20% reduction in use of PCA due to monthly limits and additional approval requirements. Waiver recipients would substitute other services

	FY2006	FY2007	FY2008	FY2009
	2,271	2,311	2,350	2,388
Total Costs	(9,588,020)	(20,493,441)	(22,043,188)	(23,565,243)
Federal	(4,794,010)	(10,246,720)	(11,021,594)	(11,782,621)
State	(4,794,010)	(10,246,720)	(11,021,594)	(11,782,621)

Increased NF or Hospital admissions based on 30% of PCA savings

	FY2006	FY2007	FY2008	FY2009
Estimated Average Recipients	69	144	152	161
Monthy Cost/Recipient	3,484	3,551	3,624	3,668
Total Costs	2,876,406	6,148,032	6,612,956	7,069,573
Federal	1,438,203	3,074,016	3,306,478	3,534,786
State	1,438,203	3,074,016	3,306,478	3,534,786

Assessment Guidelines
Develops of specific limits by dependency guidelines

	FY2006	FY2007	FY2008	FY2009
Total Costs	250,000	0	0	0
State--GF	250,000	0	0	0
Revenues--FFP (40%)	100,000	0	0	0

Assumptions:

1. Above values estimate the impact on the fee-for-service program only, and not manage care organizations.
2. Flexible Use. Increased need for PCA service updates by physicians and public health nurses would be necessary to implement flexible use provisions to make adjustments to monthly authorizations based on actual use.
3. Reduced Use of PCA Services. The provisions of section 21 through 23 would curtail the use of PCA services by 10% each year from forecasted levels for non-waiver state plan PCA recipients
   a. It is estimated that the provisions would result in a 10% reduction in PCA program use for non waiver PCA recipients(68% of Total).
   b. There is no savings for PCA recipients on waivers who can substitute other waivered services to meet their needs.
   c. The reduced use of PCA services results from the denial of hardship waivers resulting in reduced availability of PCAs, and reduced eligibility for PCA services due to delegation restrictions, administrative restrictions on flexible use and more extensive PCA authorizations processes.
   d. The savings are estimated to accrue 6 months after the effective date of the policy changes.
4. Costs offsetting PCA Savings. It is estimated that the changes will result in increased use of nursing facilities for recipients who can not secure timely reauthorization for services, or authorization for service plan changes. The cost is estimated 30% of the PCA savings, and is estimated to affect an average 70-200 recipients

Section 24 – Health Lifestyle Waiver

MMIS see section 27

Section 25- Performance Reporting & Quality Improvement Payment System
No fiscal impact.

Section 26 – Employee Scholarship

	FY2006	FY2007	FY2008	FY2009
MMIS costs	19,200	0	0	0
Federal Share	12,480	0	0	0
State Share (GF)	6,720	0	0	0

P/T contract and non-salary admin costs (This includes the cost of determining providers who must submit data, seeking and collecting the data, analyzing and compiling data for an annual report to legislature.

	FY2006	FY2007	FY2008	FY2009
Total GF Costs	35,000	35,000	35,000	35,000
Fed Reimbursement Offset (40%)	14,000	14,000	14,000	14,000

Program Costs

	(State dollars in thousands)			
	FY2006	FY2007	FY2008	FY2009
MA LTC Waivers and Home Care				
Devel. Disabilities Waiver	717	889	924	959
Elderly Waiver	114	138	131	129

CADI	168	265	327	387
CAC	9	12	15	18
TBI	71	110	134	158
Home Health Agencies	28	35	36	38
Personal Care & PDN	273	348	375	403
MA LTC Waivers and Home Care Subtotal	1,380	1,797	1,942	2,092
MA LTC Facilities				
DT&H for ICF-MR	22	26	24	22
Nursing Facilities	0	0	0	0
ICF-MR	110	115	107	100
MA LTC Facilities Subtotal	132	141	131	122
MA Basic E&D - Transfer to MH Case Mgmt	0	0	0	0
MA Basic E & D - EW Managed Care	16	60	96	129
MA Basic F&C - Non-citizens w/out FFP	0	0	0	0
MA Rehab (PT,OT,ST)	0	0	0	0
GAMC Rehab (PT,OT,ST)	0	0	0	0
MA Respiratory Therapy	0	0	0	0
GAMC Respiratory Therapy	0	0	0	0
Alternative Care Grants	107	129	129	129
GRH supplemental service payments	20	22	22	22
State share of CD Tier I	105	136	147	158
State Share of CSG	0	0	0	0
Adult Mental Health Grants	76	91	91	91
Children's Mental Health Grants	0	0	0	0
DD Comm Supp Grants SILS	11	15	15	15
Comm Soc Svc Grants, non-MA DT&H	0	0	0	0
Comm Soc Svc Grants, former GRH/SILS	0	1	1	1
Deaf and Hard of Hearing Grants	1	2	2	2
Aging and Adult Services Grants - Epilepsy	0	0	0	0
Subtotal	336	456	503	547
TOTAL GENERAL FUND ABOVE	1,848	2,394	2,576	2,761
Biennial totals		4,242		5,337

(State dollars in thousands)

Summary by budget activity	FY2006	FY2007	FY2008	FY2009
MA LTC Waivers and Home Care	1,380	1,797	1,942	2,092
MA LTC Facilities	132	141	131	122
MA Basic Health Care E&D	16	60	96	129
MA Basic Health Care F&C	0	0	0	0
GAMC Basic Health Care	0	0	0	0
Alternative Care Grants	107	129	129	129
Group Residential Housing	20	22	22	22
Adult Mental Health Grants	76	91	91	91
Children's Mental Health Grants	0	0	0	0
DD Comm Supp Grants	11	15	15	15
Comm Soc Svc Grants	0	1	1	1
Deaf and Hard of Hearing Grants	1	2	2	2
Aging and Adult Services Grants	0	0	0	0
State share of CD Tier I	105	136	147	158
Consumer Support Grants	0	0	0	0

TOTAL GENERAL FUND ABOVE	1,848	2,394	2,576	2,761
Sectin 26 GF Impact (000's)	1,890	2,429	2,611	2,796
Fed Reimbursement Offset (40%)	14	14	14	14

Assumptions

1. Continuing care service rates/allocations would be increased by .20% on July 1, 2005. The effects of the rate increase continues in SFY 2007, SFY 2008 and SFY 2009 for affected continuing care programs.

2. Nursing facility, epilepsy grants, children's mental health grants, consumer support grants are not affected by this legislation.

3. The managed care capitation for elderly waiver services would increase at the same rate as the fee-for-service program.

4. The cash effects of rate increase are phased-in based on the program and funding source. The cash estimates are based on the following phase-in for each rate increase.

- ICF/MR rates: 11/12th in the first year, and 1/12th in the second year

- Other MA funded programs including home and community based waivers, home care: 10/12th in the first year,
- and 2/12th in the second year

- State grants not appropriated as part of CCSA, such as adult mental health, SILS, etc : 9/12th in the first year,
- and 3/12th in the second year

- State grants appropriated as part of CCSA (including children's mental health, etc): 9/12th in the first year, and 3/12th in the second year.

- Other state grants such as deaf and hard of hearing: no delay

5. The county social service share of the rate increase for day training and habilitation and SILS is not funded as part of this proposal.

6. For state grant programs that have been folded into CCSA (children's mental health) the SFY 2004 grant base is used to calculate the effect of the rate increase.

7. Medical Assistance federal financial participation rates were estimated at 50% of the total costs with the state paying 100% of the non-federal share.

The only exception is for payments to larger ICFs/MR (including day training costs) and to nursing facilities for persons under 65, where the state pays 80% and the counties pay 20% of the non-federal share;

Expenditure and/or Revenue Formula

1) The operating payment rate for ICFs is estimated to be 94.4% of the total payment rate and would be increased by two/tenths of a percent on July 1, 2005.

2) For the other continuing care programs, the proposed change to the rates is as follows: .20% increase on July 1, 2005.

3) The rate increases in SFY 2006 would have ongoing effects in SFY 2007, SFY 2008 and 2009

4) The rate change for CC programs was applied to the program projections of the current department forecasts for those programs funded by the Medical Assistance or Group Residential Housing programs.

5) The rate change for CC state grant programs was applied to the respective state base to each year for those programs. For state grant programs that have been folded into CCSA (children's mental health, social service funded day training, etc) the SFY 2004 grant base was used to calculate the effect of the rate increase.

Long-Term Fiscal Considerations

Section 26 will have on-going cost effects in SFY 2008/2009 and thereafter. In the next biennium (08/09), this bill would cost the state an additional 5.3 million dollars.

Local Government Costs

Section 26 will increase the cost to counties. These costs are related the rate increases to the county share on day training and habilitation services paid by social service dollars, county share for semi-independent living services, and the country share for ICFs/MR.

Section 27 – GAMC Co-payments

HealthMatch impact

	FY2006	FY2007	FY2008	FY2009
MMIS costs	29,600	0	0	0
Federal Share	19,240	0	0	0
State Share (GF)	10,360	0	0	0

2005 Session
SF 65, Section 27 (smoking cessation GAMC)

Waiver of copays for people in GAMC who do not smoke or who are in a smoking cessation program

Assumptions: 1) approximately 45% of people in our programs smoke - leaving 55 % who do not
2) guessing that about 10% of the smokers may be in a program - approx 4% of the total

55 + 4= 59% of the GAMC population is either non-smoking or in a program

CY 2004 - $895,992 was deducted from payment to providers for FFS GAMC
59% = $528,635 cost if copays are waived

	CY2004	FY06	FY07	FY08	FY09
Trending	528,635	613,217	766,521	872,248	935,684

Less Phase-in (50%)		-306,608			
Net GAMC Costs GF:	528,635	306,608	766,521	872,248	935,684
Section 27 GF impact		316,968	766,521	872,248	935,684

Section 28 – Restores MinnesotaCare MCHA Exception

HealthMatch impact

Section 28 MCHA Exemption
Staff needed in MinnesotaCare Operations due to small increase in enrollment. Costs include salary, fringe, and overhead, + postage and printing cost increases.

	FY2006	FY2007	FY2008	FY2009
FTE required for MNCare Ops	1	1	1	1
Enroll. Staff + Printing and Postage	33,436	54,369	41,889	43,279
Total --HCAF	33,436	54,369	41,889	43,279
Fed Reimbursement Offset (40%)	13,374	21,748	16,756	17,312

Program Costs
MINNESOTACARE
Fiscal Analysis of a Proposal to
Restore the MCHA Exemption for Parents and Adults with No Children
Session 2005
Senate File 65: Section 28

		FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN Caretakers					
Number of eligibles		37	192	200	207
Avg. monthly payment		364.03	382.9	408.71	443.95
Avg. monthly revenue		$322	$342	$368	$395
Total payments		162,529	881,020	980,760	1,104,258
	Federal share %	0.00%	0.00%	0.00%	0.00%
	Federal share	0	0	0	0
	State share	162,529	881,020	980,760	1,104,258
Total revenue		143,763	786,902	882,232	983,058

	Federal share %	0.00%	0.00%	0.00%	0.00%
	Federal share	0	0	0	0
	State share	143,763	786,902	882,232	983,058
Net cost		18,766	94,118	98,528	121,199
	Federal share	0	0	0	0
	State share	18,766	94,118	98,528	121,199

ADULTS WITHOUT CHILDREN

Number of eligibles	179	383	400	415
Avg. monthly payment	410.82	461.89	450.24	444.33
Avg. monthly revenue	$80.00	$80.00	$80.00	$80.00
Total payments	880,400	2,125,491	2,160,828	2,210,420
Total revenue	171,444	368,141	383,944	397,975
Net state cost	708,956	1,757,350	1,776,884	1,812,444

TOTAL PROGRAM

Net State Cost	$727,722	$1,851,467	$1,875,412	$1,933,643
Health Care Access Fund				
Section 28 impact to HCAF	761,158	1,905,836	1,917,301	1,976,922
Section 28 FFP to HCAF	13,374	21,748	16,756	17,312

Section 29 - MinnesotaCare Small Employer Option

HealthMatch impact

	FY2006	FY2007	FY2008	FY2009
MMIS costs	321,000	0	0	0
Federal Share	208,650	0	0	0
State Share (GF)	112,350	0	0	0

Other Admin Costs

Policy and program development, and training needs (costs include salary, fringe, and overhead). 1 FTE needed for developing policy, implementing program and policy for MNCare Small Employers Option, and .5 FTE needed for County training

	FY2006	FY2007	FY2008	FY2009
	1.5	1	0	0
FTE costs–GF	133,500	78,500	0	0
Fed Reimbursement Offset (40%)	53,400	31,400	0	0

Section 29--MNCare Option for Small Employers
Staff needed in MinnesotaCare Operations to enroll additional eligibles, and maintain their eligibility. Costs include salary, fringe, overhead.

	FY2006	FY2007	FY2008	FY2009
FTE needed	4	9	7	6
Costs for FTE	275,586	644,296	458,203	402,784
Costs for postage and printing	21,044	49,260	47,947	43,879
Total Costs-HCAF	296,630	693,556	506,150	446,663
Fed Reimbursement Offset (40%)	118,652	277,422	202,460	178,665

Program Costs
MINNESOTACARE

Fiscal Analysis of a Proposal to
Provide an Option for Small Employers
2005 Session
Senate File 65: Section 29

This section provides an option for small employers (2-50 employees) to enroll uninsured employees and dependents in MinnesotaCare.
To use this option employers must enroll 75% of their employees who not not have other health coverage. The employer must not have provided employer-subsidized health coverage during the previous 12 months.
For enrollees within the income limits of the MinnesotaCare program (175% FPG for singles / 275% FPG for families) the employer must pay an amount equal to 50% of the MinnesotaCare full cost premium. For enrollees over these limits the employer must pay the entire full cost premium but may charge the employee up to 50% of the full cost premium.

The following data describes the estimated population of employees and their dependents of businesses that do not offer health coverage. (estimates provided by Health Economics Minnesota Dept. of Health):

Employed by Small Employer (2-50) Not Offering Health Coverage

Uninsured Employees / Dependents

		Status If Covered		
	Total	Number of Single Persons	Number of Family Persons	Family Policies
All	58,000	28,000	30,000	7,900
Within income limits	32,000	8,300	23,700	6,100
Above income limits	26,000	19,700	6,300	1,800

Insured Employees / Dependents

			Purchase Individual	Group Coverage Through

	Total	Coverage	Spouse
All	224,500	79,500	145,000
Within income limits	44,500	18,500	26,000
Above income limits	180,000	61,000	119,000

Employed by Small Employer (2-50) Not Offering Health Coverage

Insured Employees / Dependents

	Total	Individual Coverage	Family Members
All	282,500	107,500	175,000
Within income limits	76,500	26,800	49,700
Above income limits	206,000	80,700	125,300

"Healthy New York", a generally similar program experienced an enrollment rate after two years equal to 1.1% of the number of employees in small firms not offering coverage. MinnesotaCare offers more comprehensive coverage, but the cost to employers, assuming 50% of the full cost premium, is about 50%
higher than in Healthy New York.

Based on this experience, we assume an average enrollment rate of 2.2% from the total population of uninsured or insured employees and dependents of small firms not offering health coverage. (Twice the rate experienced in "Healthy New York," to allow that response in Minnesota may be somewhat different.) We assume relatively higher enrollment by families with children, and relatively higher enrollment by the more subsidized group within MinnesotaCare income limits. We assume 5% enrollment by family members and 3% enrollment by individuals in the more subsidized group within MinnesotaCare income limits. Enrollment by the group above MinnesotaCare income limits is projected at one-third of the rates for those within the limits. Implementation in March 2005 is assumed.

	Total	Individuals	Family Members
Enrollment Rates			
All	2.19%	1.50%	2.61%
Within income limits	4.30%	3.00%	5.00%
Above income limits	1.41%	1.00%	1.67%

Enrollment

All	6,184	1,611	4,573
Within income limits	3,289	804	2,485
Above income limits	2,895	807	2,088

	FY 2006	FY 2007	FY 2008	FY 2009
FAMILIES WITH CHILDREN				
Average number of enrollees:				
Pregnant women	6	54	72	72
Under age 2	16	147	196	196
Other children & parents	359	3,229	4,305	4,305
Total	381	3,430	4,573	4,573
Avg. monthly payment				
Pregnant women	476.07	512.01	507.28	574.3
Under age 2	403.55	431.18	429.83	490.92
Other children & parents	254.66	291.72	322.62	351.07
Total payments				
Pregnant women	34,182	330,869	437,079	494,824
Under age 2	79,174	761,358	1,011,961	1,155,793
Other children & parents	1,096,387	11,303,505	16,667,596	18,137,678
Total	1,209,744	12,395,732	18,116,636	19,788,294
ADULTS WITHOUT CHILDREN				
Average number of enrollees	134	1,208	1,611	1,611
Avg. monthly payment	402.01	433.43	470.3	508.52
Total payments	647,644	6,284,334	9,091,766	9,830,730
REVENUE				
Family enrollees @ 50% of full cost	207	1,864	2,485	2,485
Adj. for family enrollees over 3	-37	-335	-447	-447
Family enrollees charged @ 50% of full cost	170	1,528	2,038	2,038
Individual enrollees @ 50% of full cost	67	603	804	804
Total enrollees charged @ 50% of full cost	237	2,131	2,842	2,842
Family enrollees @ full cost	174	1,566	2,088	2,088
Adj. for family enrollees over 3	-31	-282	-376	-376
Family enrollees charged @ full cost	143	1,284	1,712	1,712
Individual enrollees @ full cost	67	605	807	807
Total enrollees charged @ full cost	210	1,890	2,519	2,519
Half of full cost premium	161	171	184	198

Full cost premium	322	342	368	395
Revenue @ 50% of full cost	457,514	4,373,376	6,268,506	6,738,644
Revenue @ full cost	811,258	7,754,816	11,115,236	11,948,879
Total revenue	1,268,771	12,128,192	17,383,742	18,687,523
NET COST-HCAF	588,617	6,551,874	9,824,660	10,931,501

	FY 2006	FY 2007	FY 2008	FY 2009
Section 29--GF Impact	112,350	0	0	0
Section 29--HCAF Impact	885,247	7,245,430	10,330,810	11,378,164
Section 29--FFP HCAF	118,652	277,422	202,460	178,665

Section 30-Limiting Coverage of Health Care Services

See NEW section 19 for related costs and savings.

Section 31- Child Obesity Task Force
No fiscal impact.

New Section 34--Training

Requires training of physicians, public health nurses, consumers, responsible parties

	FY 2006	FY 2007	FY 2008	FY 2009
Total Costs	250,000	150,000	50,000	50,000
State--GF	250,000	150,000	50,000	50,000
Revenues FFP	100,000	60,000	20,000	20,000

NEW-Section 35 Rate Reduction
Not Specified

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

I have reviewed the content of this fiscal note and believe it is a reasonable estimate of the expenditures and revenues associated with this proposed legislation.

Fiscal Note Coordinator Signature: _____ Date: _____

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. 65 as follows:

Page 23, line 20, before the period, insert ", that agrees to participate in the prescription drug discount program"

Page 25, line 12, delete "pharmacy's" and insert "medical assistance reimbursement rate"

Page 25, delete line 13

Page 25, line 14, delete everything before the comma

Page 26, delete lines 4 to 8

Page 26, line 9, delete "10" and insert "9"

Page 26, line 17, delete "11" and insert "10"

Page 27, after line 1, insert:

"**[EFFECTIVE DATE.]** This section is effective August 1, 2006, or upon health match implementation, whichever is later."

Page 36, lines 22 to 36, delete the new language

Page 37, lines 1 to 3, delete the new language

Page 52, line 6, before the period, insert "for reimbursement under chapters 256B, 256D, and 256L"

Page 52, line 7, delete "by" and insert "under the direction of"

Page 52, line 16, delete "may" and insert "shall"

Page 52, line 17, before the period, insert "or a pro-like entity eligible to operate in Minnesota"

Page 52, delete lines 21 to 31 and insert:

"Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) chiropractic visits beyond ten visits;

(5) circumcision; and

(6) orthodontia."

Page 53, line 6, delete "health" and insert "human services"

Page 53, line 7, delete "human services" and insert "health"

and delete "a" and insert "an interagency work group"

Page 53, line 8, delete "task force"

Page 53, line 32, delete "task force" and insert "work group"

ATTACHMENT "D"

Senator ..... moves to amend S.F. No. 65 as follows:

Page 54, after line 23, insert:

"Sec. 33. [AIDS PREVENTION INITIATIVE FOCUSING ON AFRICAN-BORN RESIDENTS.]

The commissioner of health shall award grants in accordance with Minnesota Statutes, section 145.924, paragraph (b), for a public education and awareness campaign targeting communities of African-born Minnesota residents. The grants shall be designed to promote knowledge and understanding about HIV and to increase knowledge in order to eliminate and reduce the risk for HIV infection; to encourage screening and testing for HIV; and to link individuals to public health and health care resources. The grants must be awarded to collaborative efforts that bring together nonprofit community-based groups with demonstrated experience in addressing the public health, health care, and social service needs of African-born communities."

Page 55, after line 3, insert:

"(c) $300,000 is appropriated for fiscal year 2006 from the general fund to the commissioner of health for the purpose of a public education and awareness campaign targeting communities of African-born Minnesota residents. This appropriation is a onetime appropriation and shall not become part of the base-level funding for the 2006-2007 biennium."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "E"

Senator ..... moves to amend S.F. No. 65 as follows:

Page 51, after line 36, insert:

"Sec. 30. Minnesota Statutes 2004, section 295.582, is amended to read:

295.582 [AUTHORITY.]

Subdivision 1. [WHOLESALE DRUG DISTRIBUTOR TAX.] (a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit a pharmacy from transferring the additional expense generated under section 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits manager must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the transferred expense in addition to any payments due under existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. For purposes of this section, a pharmacy benefits manager means an

entity that performs pharmacy benefits management. A third-party purchaser or pharmacy benefits manager shall comply with this section regardless of whether the third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Each third-party purchaser regulated under any chapter cited in paragraph (a) shall include with its annual renewal for certification of authority or licensure documentation indicating compliance with paragraph (a).

(c) Any hospital, surgical center, or health care provider subject to a tax under section 295.52 or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor may file a complaint with the commissioner responsible for regulating the third-party purchaser if at any time the third-party purchaser fails to comply with paragraph (a).

(d) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may

appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Subd. 2. [AGREEMENT.] A contracting agreement between a third-party purchaser or a pharmacy benefits manager and a resident or nonresident pharmacy registered under chapter 151, may not prohibit:

(1) a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor from exercising its option under this section to transfer such additional expenses generated by the section 295.52 obligations on to the third-party purchaser or pharmacy benefits manager; or

(2) a pharmacy that is subject to tax under section 295.52, subdivision 4, from exercising its option under this section to recover all or part of the section 295.52 obligations from the third-party purchaser or a pharmacy benefits manager."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "F"

Senator ..... moves to amend S.F. No. 65 as follows:

Page 55, after line 3, insert:

"(c) $500,000 is appropriated each year of the biennium beginning July 1, 2005, from the lottery prize fund to the commissioner of human services for a grant to the Southeast Asian Problem Gambling Consortium, with the Lao Assistance Center as the fiscal agent, to provide statewide compulsive gambling prevention and treatment services for Lao, Hmong, Vietnamese, and Cambodian families, adults, and adolescents. Any unencumbered balance remaining at the end of the first fiscal year of a biennium does not cancel, but is available the second fiscal year of the biennium."