

1.1 Liebling from the Health and Human Services Finance Division to which was referred:

1.2 H. F. No. 1914, A bill for an act relating to health; adding advanced practice registered  
1.3 nurses to certain statutes; amending Minnesota Statutes 2018, sections 62D.09, subdivision  
1.4 1; 62E.06, subdivision 1; 62J.17, subdivision 4a; 62J.23, subdivision 2; 62J.495, subdivision  
1.5 1a; 62J.52, subdivision 2; 62J.823, subdivision 3; 62Q.184, subdivision 1; 62Q.43,  
1.6 subdivisions 1, 2; 62Q.54; 62Q.57, subdivision 1; 62Q.73, subdivision 7; 62Q.733,  
1.7 subdivision 3; 62Q.74, subdivision 1; 62S.08, subdivision 3; 62S.20, subdivision 5b; 62S.21,  
1.8 subdivision 2; 62S.268, subdivision 1; 144.3345, subdivision 1; 144.3352; 144.34; 144.441,  
1.9 subdivisions 4, 5; 144.442, subdivision 1; 144.4803, subdivisions 1, 4, 10, by adding a  
1.10 subdivision; 144.4806; 144.4807, subdivisions 1, 2, 4; 144.50, subdivision 2; 144.55,  
1.11 subdivisions 2, 6; 144.6501, subdivision 7; 144.651, subdivisions 7, 8, 9, 10, 12, 14, 31,  
1.12 33; 144.652, subdivision 2; 144.69; 144.7402, subdivision 2; 144.7406, subdivision 2;  
1.13 144.7407, subdivision 2; 144.7414, subdivision 2; 144.7415, subdivision 2; 144.9502,  
1.14 subdivision 4; 144.966, subdivisions 3, 6; 144A.135; 144A.161, subdivisions 5, 5a, 5e, 5g;  
1.15 144A.75, subdivisions 3, 6; 144A.752, subdivision 1; 145.853, subdivision 5; 145.892,  
1.16 subdivision 3; 145.94, subdivision 2; 145B.13; 145C.02; 145C.05, subdivision 2; 145C.06;  
1.17 145C.07, subdivision 1; 145C.16; 148.6438, subdivision 1; 151.19, subdivision 4; 151.21,  
1.18 subdivision 4a; 152.32, subdivision 3; 245.4871, subdivision 27; 245.62, subdivision 3;  
1.19 245A.143, subdivision 8; 245A.1435; 245C.02, subdivision 18; 245C.04, subdivision 1;  
1.20 245D.02, subdivision 11; 245D.11, subdivision 2; 245D.22, subdivision 7; 245D.25,  
1.21 subdivision 2; 245G.08, subdivisions 2, 3, 5; 245G.21, subdivisions 2, 3; 245G.22,  
1.22 subdivisions 3, 4, 6, 7, 16; 245H.11; 246.711, subdivision 2; 246.715, subdivision 2; 246.716,  
1.23 subdivision 2; 246.721; 246.722; 251.043, subdivision 1; 252A.02, subdivision 12; 252A.04,  
1.24 subdivision 2; 252A.20, subdivision 1; 253B.03, subdivisions 4, 6d; 253B.06, subdivisions  
1.25 1, 2; 253B.07, subdivision 2; 253B.08, subdivision 5; 253B.092, subdivisions 2, 3, 6, 8;  
1.26 253B.0921; 253B.20, subdivisions 4, 6; 253B.23, subdivision 4; 254A.08, subdivision 2;  
1.27 256.9685, subdivisions 1a, 1b, 1c; 256.975, subdivisions 7a, 11; 256B.038; 256B.04,  
1.28 subdivision 14a; 256B.043, subdivision 2; 256B.055, subdivision 12; 256B.0622,  
1.29 subdivisions 2b, 8; 256B.0623, subdivision 2; 256B.0625, subdivisions 3, 4, 13, 17, 26, 28,  
1.30 60a; 256B.0654, subdivisions 1, 2a, 3, 4; 256B.0659, subdivisions 2, 4, 8, 11; 256B.0913,  
1.31 subdivision 8; 256B.73, subdivision 5; 256J.08, subdivision 73a; 256R.44; 256R.54,  
1.32 subdivisions 1, 2; 257.63, subdivision 3; 257B.01, subdivisions 3, 9, 10; 257B.06, subdivision  
1.33 7.

1.34 Reported the same back with the following amendments:

1.35 Page 6, delete section 4 and insert:

2.1 "Sec. 4. Minnesota Statutes 2019 Supplement, section 62J.23, subdivision 2, is amended  
2.2 to read:

2.3 Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner  
2.4 under this section, the restrictions in the federal Medicare antikickback statutes in section  
2.5 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and  
2.6 rules adopted under the federal statutes, apply to all persons in the state, regardless of whether  
2.7 the person participates in any state health care program.

2.8 (b) Nothing in paragraph (a) shall be construed to prohibit an individual from receiving  
2.9 a discount or other reduction in price or a limited-time free supply or samples of a prescription  
2.10 drug, medical supply, or medical equipment offered by a pharmaceutical manufacturer,  
2.11 medical supply or device manufacturer, health plan company, or pharmacy benefit manager,  
2.12 so long as:

2.13 (1) the discount or reduction in price is provided to the individual in connection with  
2.14 the purchase of a prescription drug, medical supply, or medical equipment prescribed for  
2.15 that individual;

2.16 (2) it otherwise complies with the requirements of state and federal law applicable to  
2.17 enrollees of state and federal public health care programs;

2.18 (3) the discount or reduction in price does not exceed the amount paid directly by the  
2.19 individual for the prescription drug, medical supply, or medical equipment; and

2.20 (4) the limited-time free supply or samples are provided by a physician, advanced practice  
2.21 registered nurse, or pharmacist, as provided by the federal Prescription Drug Marketing  
2.22 Act.

2.23 For purposes of this paragraph, "prescription drug" includes prescription drugs that are  
2.24 administered through infusion, and related services and supplies.

2.25 (c) No benefit, reward, remuneration, or incentive for continued product use may be  
2.26 provided to an individual or an individual's family by a pharmaceutical manufacturer,  
2.27 medical supply or device manufacturer, or pharmacy benefit manager, except that this  
2.28 prohibition does not apply to:

2.29 (1) activities permitted under paragraph (b);

2.30 (2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan  
2.31 company, or pharmacy benefit manager providing to a patient, at a discount or reduced  
2.32 price or free of charge, ancillary products necessary for treatment of the medical condition

3.1 for which the prescription drug, medical supply, or medical equipment was prescribed or  
3.2 provided; and

3.3 (3) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan  
3.4 company, or pharmacy benefit manager providing to a patient a trinket or memento of  
3.5 insignificant value.

3.6 (d) Nothing in this subdivision shall be construed to prohibit a health plan company  
3.7 from offering a tiered formulary with different co-payment or cost-sharing amounts for  
3.8 different drugs."

3.9 Page 9, delete section 8 and insert:

3.10 "Sec. 8. Minnesota Statutes 2019 Supplement, section 62Q.184, subdivision 1, is amended  
3.11 to read:

3.12 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this  
3.13 subdivision have the meanings given them.

3.14 (b) "Clinical practice guideline" means a systematically developed statement to assist  
3.15 health care providers and enrollees in making decisions about appropriate health care services  
3.16 for specific clinical circumstances and conditions developed independently of a health plan  
3.17 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical  
3.18 practice guideline also includes a preferred drug list developed in accordance with section  
3.19 256B.0625.

3.20 (c) "Clinical review criteria" means the written screening procedures, decision abstracts,  
3.21 clinical protocols, and clinical practice guidelines used by a health plan company to determine  
3.22 the medical necessity and appropriateness of health care services.

3.23 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but  
3.24 also includes a county-based purchasing plan participating in a public program under chapter  
3.25 256B or 256L and an integrated health partnership under section 256B.0755.

3.26 (e) "Step therapy protocol" means a protocol or program that establishes the specific  
3.27 sequence in which prescription drugs for a specified medical condition, including  
3.28 self-administered drugs and ~~physician-administered~~ drugs that are administered by a physician  
3.29 or advanced practice registered nurse, are medically appropriate for a particular enrollee  
3.30 and are covered under a health plan.

4.1 (f) "Step therapy override" means that the step therapy protocol is overridden in favor  
4.2 of coverage of the selected prescription drug of the prescribing health care provider because  
4.3 at least one of the conditions of subdivision 3, paragraph (a), exists."

4.4 Page 25, delete section 35 and insert:

4.5 "Sec. 35. Minnesota Statutes 2019 Supplement, section 144.55, subdivision 2, is amended  
4.6 to read:

4.7 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision  
4.8 have the meanings given them.

4.9 (b) "Outpatient surgical center" or "center" means a facility organized for the specific  
4.10 purpose of providing elective outpatient surgery for preexamined, prediagnosed, low-risk  
4.11 patients. An outpatient surgical center is not organized to provide regular emergency medical  
4.12 services and does not include a physician's, advanced practice registered nurse's, or dentist's  
4.13 office or clinic for the practice of medicine, the practice of dentistry, or the delivery of  
4.14 primary care.

4.15 (c) "Approved accrediting organization" means any organization recognized as an  
4.16 accreditation organization by the Centers for Medicare and Medicaid Services."

4.17 Page 43, delete section 69 and insert:

4.18 "Sec. 69. Minnesota Statutes 2019 Supplement, section 145C.05, subdivision 2, is amended  
4.19 to read:

4.20 Subd. 2. **Provisions that may be included.** (a) A health care directive may include  
4.21 provisions consistent with this chapter, including, but not limited to:

4.22 (1) the designation of one or more alternate health care agents to act if the named health  
4.23 care agent is not reasonably available to serve;

4.24 (2) directions to joint health care agents regarding the process or standards by which the  
4.25 health care agents are to reach a health care decision for the principal, and a statement  
4.26 whether joint health care agents may act independently of one another;

4.27 (3) limitations, if any, on the right of the health care agent or any alternate health care  
4.28 agents to receive, review, obtain copies of, and consent to the disclosure of the principal's  
4.29 medical records or to visit the principal when the principal is a patient in a health care  
4.30 facility;

5.1 (4) limitations, if any, on the nomination of the health care agent as guardian for purposes  
5.2 of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

5.3 (5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter  
5.4 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

5.5 (6) a declaration regarding intrusive mental health treatment under section 253B.03,  
5.6 subdivision 6d, or a statement that the health care agent is authorized to give consent for  
5.7 the principal under section 253B.04, subdivision 1a;

5.8 (7) a funeral directive as provided in section 149A.80, subdivision 2;

5.9 (8) limitations, if any, to the effect of dissolution or annulment of marriage or termination  
5.10 of domestic partnership on the appointment of a health care agent under section 145C.09,  
5.11 subdivision 2;

5.12 (9) specific reasons why a principal wants a health care provider or an employee of a  
5.13 health care provider attending the principal to be eligible to act as the principal's health care  
5.14 agent;

5.15 (10) health care instructions by a woman of child bearing age regarding how she would  
5.16 like her pregnancy, if any, to affect health care decisions made on her behalf;

5.17 (11) health care instructions regarding artificially administered nutrition or hydration;  
5.18 and

5.19 (12) health care instructions to prohibit administering, dispensing, or prescribing an  
5.20 opioid, except that these instructions must not be construed to limit the administering,  
5.21 dispensing, or prescribing an opioid to treat substance abuse, opioid dependence, or an  
5.22 overdose, unless otherwise prohibited in the health care directive.

5.23 (b) A health care directive may include a statement of the circumstances under which  
5.24 the directive becomes effective other than upon the judgment of the principal's attending  
5.25 physician or advanced practice registered nurse in the following situations:

5.26 (1) a principal who in good faith generally selects and depends upon spiritual means or  
5.27 prayer for the treatment or care of disease or remedial care and does not have an attending  
5.28 physician or advanced practice registered nurse, may include a statement appointing an  
5.29 individual who may determine the principal's decision-making capacity; and

5.30 (2) a principal who in good faith does not generally select a physician, advanced practice  
5.31 registered nurse, or a health care facility for the principal's health care needs may include  
5.32 a statement appointing an individual who may determine the principal's decision-making

6.1 capacity, provided that if the need to determine the principal's capacity arises when the  
6.2 principal is receiving care under the direction of an attending physician or advanced practice  
6.3 registered nurse in a health care facility, the determination must be made by an attending  
6.4 physician or advanced practice registered nurse after consultation with the appointed  
6.5 individual.

6.6 If a person appointed under clause (1) or (2) is not reasonably available and the principal  
6.7 is receiving care under the direction of an attending physician or advanced practice registered  
6.8 nurse in a health care facility, an attending physician or advanced practice registered nurse  
6.9 shall determine the principal's decision-making capacity.

6.10 (c) A health care directive may authorize a health care agent to make health care decisions  
6.11 for a principal even though the principal retains decision-making capacity."

6.12 Page 55, delete section 77

6.13 Page 56, delete section 78

6.14 Page 65, delete section 88 and insert:

6.15 "Sec. 88. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended  
6.16 to read:

6.17 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone  
6.18 available for emergency treatment of opioid overdose must have a written standing order  
6.19 protocol by a physician who is licensed under chapter 147 or an advanced practice registered  
6.20 nurse who is licensed under chapter 148, that permits the license holder to maintain a supply  
6.21 of naloxone on site. A license holder must require staff to undergo training in the specific  
6.22 mode of administration used at the program, which may include intranasal administration,  
6.23 intramuscular injection, or both."

6.24 Page 68, delete sections 92 and 93

6.25 Page 69, delete sections 94 and 95

6.26 Page 70, delete section 96

6.27 Page 72, delete section 97 and insert:

7.1 "Sec. 97. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

7.2 **245H.11 REPORTING.**

7.3 (a) The certification holder must comply and must have written policies for staff to  
 7.4 comply with the reporting requirements for abuse and neglect specified in section 626.556.  
 7.5 A person mandated to report physical or sexual child abuse or neglect occurring within a  
 7.6 certified center shall report the information to the commissioner.

7.7 (b) The certification holder must inform the commissioner within 24 hours of:

7.8 (1) the death of a child in the program; and

7.9 (2) any injury to a child in the program that required treatment by a physician or advanced  
 7.10 practice registered nurse."

7.11 Page 78, delete section 109

7.12 Page 79, delete section 111

7.13 Page 80, delete sections 112 and 113

7.14 Page 81, delete section 114

7.15 Page 82, delete section 115

7.16 Page 83, delete section 116

7.17 Page 85, delete sections 117 to 119

7.18 Page 85, line 32, delete "advanced practice"

7.19 Page 86, line 2, delete "advanced practice"

7.20 Page 90, delete section 127

7.21 Page 97, delete section 132

7.22 Page 100, delete sections 134 and 135

7.23 Page 101, delete section 136 and insert:

7.24 "Sec. 136. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to  
 7.25 read:

7.26 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers  
 7.27 eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed  
 7.28 practitioner.

8.1 (b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"  
8.2 includes a physician, an advanced practice registered nurse, or a podiatrist.

8.3 Sec. 137. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is  
8.4 amended to read:

8.5 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when  
8.6 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed  
8.7 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a  
8.8 dispensing physician, or by a physician, physician assistant, or ~~a nurse practitioner~~ advanced  
8.9 practice registered nurse employed by or under contract with a community health board as  
8.10 defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

8.11 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,  
8.12 unless authorized by the commissioner.

8.13 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
8.14 ingredient" is defined as a substance that is represented for use in a drug and when used in  
8.15 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
8.16 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle  
8.17 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
8.18 excipients which are included in the medical assistance formulary. Medical assistance covers  
8.19 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
8.20 when the compounded combination is specifically approved by the commissioner or when  
8.21 a commercially available product:

8.22 (1) is not a therapeutic option for the patient;

8.23 (2) does not exist in the same combination of active ingredients in the same strengths  
8.24 as the compounded prescription; and

8.25 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded  
8.26 prescription.

8.27 (d) Medical assistance covers the following over-the-counter drugs when prescribed by  
8.28 a licensed practitioner or by a licensed pharmacist who meets standards established by the  
8.29 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family  
8.30 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults  
8.31 with documented vitamin deficiencies, vitamins for children under the age of seven and  
8.32 pregnant or nursing women, and any other over-the-counter drug identified by the  
8.33 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,



9.1 and cost-effective for the treatment of certain specified chronic diseases, conditions, or  
9.2 disorders, and this determination shall not be subject to the requirements of chapter 14. A  
9.3 pharmacist may prescribe over-the-counter medications as provided under this paragraph  
9.4 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter  
9.5 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine  
9.6 necessity, provide drug counseling, review drug therapy for potential adverse interactions,  
9.7 and make referrals as needed to other health care professionals.

9.8 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
9.9 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
9.10 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
9.11 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
9.12 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
9.13 individuals, medical assistance may cover drugs from the drug classes listed in United States  
9.14 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
9.15 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
9.16 not be covered.

9.17 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing  
9.18 Program and dispensed by 340B covered entities and ambulatory pharmacies under common  
9.19 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired  
9.20 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies."

9.21 Page 103, delete section 137 and insert:

9.22 "Sec. 138. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is  
9.23 amended to read:

9.24 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"  
9.25 means motor vehicle transportation provided by a public or private person that serves  
9.26 Minnesota health care program beneficiaries who do not require emergency ambulance  
9.27 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

9.28 (b) Medical assistance covers medical transportation costs incurred solely for obtaining  
9.29 emergency medical care or transportation costs incurred by eligible persons in obtaining  
9.30 emergency or nonemergency medical care when paid directly to an ambulance company,  
9.31 nonemergency medical transportation company, or other recognized providers of  
9.32 transportation services. Medical transportation must be provided by:

10.1 (1) nonemergency medical transportation providers who meet the requirements of this  
10.2 subdivision;

10.3 (2) ambulances, as defined in section 144E.001, subdivision 2;

10.4 (3) taxicabs that meet the requirements of this subdivision;

10.5 (4) public transit, as defined in section 174.22, subdivision 7; or

10.6 (5) not-for-hire vehicles, including volunteer drivers.

10.7 (c) Medical assistance covers nonemergency medical transportation provided by  
10.8 nonemergency medical transportation providers enrolled in the Minnesota health care  
10.9 programs. All nonemergency medical transportation providers must comply with the  
10.10 operating standards for special transportation service as defined in sections 174.29 to 174.30  
10.11 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the  
10.12 commissioner and reported on the claim as the individual who provided the service. All  
10.13 nonemergency medical transportation providers shall bill for nonemergency medical  
10.14 transportation services in accordance with Minnesota health care programs criteria. Publicly  
10.15 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the  
10.16 requirements outlined in this paragraph.

10.17 (d) An organization may be terminated, denied, or suspended from enrollment if:

10.18 (1) the provider has not initiated background studies on the individuals specified in  
10.19 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

10.20 (2) the provider has initiated background studies on the individuals specified in section  
10.21 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

10.22 (i) the commissioner has sent the provider a notice that the individual has been  
10.23 disqualified under section 245C.14; and

10.24 (ii) the individual has not received a disqualification set-aside specific to the special  
10.25 transportation services provider under sections 245C.22 and 245C.23.

10.26 (e) The administrative agency of nonemergency medical transportation must:

10.27 (1) adhere to the policies defined by the commissioner in consultation with the  
10.28 Nonemergency Medical Transportation Advisory Committee;

10.29 (2) pay nonemergency medical transportation providers for services provided to  
10.30 Minnesota health care programs beneficiaries to obtain covered medical services;

11.1 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled  
11.2 trips, and number of trips by mode; and

11.3 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single  
11.4 administrative structure assessment tool that meets the technical requirements established  
11.5 by the commissioner, reconciles trip information with claims being submitted by providers,  
11.6 and ensures prompt payment for nonemergency medical transportation services.

11.7 (f) Until the commissioner implements the single administrative structure and delivery  
11.8 system under subdivision 18e, clients shall obtain their level-of-service certificate from the  
11.9 commissioner or an entity approved by the commissioner that does not dispatch rides for  
11.10 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

11.11 (g) The commissioner may use an order by the recipient's attending physician, advanced  
11.12 practice registered nurse, or a medical or mental health professional to certify that the  
11.13 recipient requires nonemergency medical transportation services. Nonemergency medical  
11.14 transportation providers shall perform driver-assisted services for eligible individuals, when  
11.15 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's  
11.16 residence or place of business, assistance with admittance of the individual to the medical  
11.17 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,  
11.18 or stretchers in the vehicle.

11.19 Nonemergency medical transportation providers must take clients to the health care  
11.20 provider using the most direct route, and must not exceed 30 miles for a trip to a primary  
11.21 care provider or 60 miles for a trip to a specialty care provider, unless the client receives  
11.22 authorization from the local agency.

11.23 Nonemergency medical transportation providers may not bill for separate base rates for  
11.24 the continuation of a trip beyond the original destination. Nonemergency medical  
11.25 transportation providers must maintain trip logs, which include pickup and drop-off times,  
11.26 signed by the medical provider or client, whichever is deemed most appropriate, attesting  
11.27 to mileage traveled to obtain covered medical services. Clients requesting client mileage  
11.28 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical  
11.29 services.

11.30 (h) The administrative agency shall use the level of service process established by the  
11.31 commissioner in consultation with the Nonemergency Medical Transportation Advisory  
11.32 Committee to determine the client's most appropriate mode of transportation. If public transit  
11.33 or a certified transportation provider is not available to provide the appropriate service mode  
11.34 for the client, the client may receive a onetime service upgrade.

12.1 (i) The covered modes of transportation are:

12.2 (1) client reimbursement, which includes client mileage reimbursement provided to  
12.3 clients who have their own transportation, or to family or an acquaintance who provides  
12.4 transportation to the client;

12.5 (2) volunteer transport, which includes transportation by volunteers using their own  
12.6 vehicle;

12.7 (3) unassisted transport, which includes transportation provided to a client by a taxicab  
12.8 or public transit. If a taxicab or public transit is not available, the client can receive  
12.9 transportation from another nonemergency medical transportation provider;

12.10 (4) assisted transport, which includes transport provided to clients who require assistance  
12.11 by a nonemergency medical transportation provider;

12.12 (5) lift-equipped/ramp transport, which includes transport provided to a client who is  
12.13 dependent on a device and requires a nonemergency medical transportation provider with  
12.14 a vehicle containing a lift or ramp;

12.15 (6) protected transport, which includes transport provided to a client who has received  
12.16 a prescreening that has deemed other forms of transportation inappropriate and who requires  
12.17 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety  
12.18 locks, a video recorder, and a transparent thermoplastic partition between the passenger and  
12.19 the vehicle driver; and (ii) who is certified as a protected transport provider; and

12.20 (7) stretcher transport, which includes transport for a client in a prone or supine position  
12.21 and requires a nonemergency medical transportation provider with a vehicle that can transport  
12.22 a client in a prone or supine position.

12.23 (j) The local agency shall be the single administrative agency and shall administer and  
12.24 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the  
12.25 commissioner has developed, made available, and funded the web-based single administrative  
12.26 structure, assessment tool, and level of need assessment under subdivision 18e. The local  
12.27 agency's financial obligation is limited to funds provided by the state or federal government.

12.28 (k) The commissioner shall:

12.29 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,  
12.30 verify that the mode and use of nonemergency medical transportation is appropriate;

12.31 (2) verify that the client is going to an approved medical appointment; and

12.32 (3) investigate all complaints and appeals.

13.1 (l) The administrative agency shall pay for the services provided in this subdivision and  
13.2 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,  
13.3 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary  
13.4 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

13.5 (m) Payments for nonemergency medical transportation must be paid based on the client's  
13.6 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The  
13.7 medical assistance reimbursement rates for nonemergency medical transportation services  
13.8 that are payable by or on behalf of the commissioner for nonemergency medical  
13.9 transportation services are:

13.10 (1) \$0.22 per mile for client reimbursement;

13.11 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer  
13.12 transport;

13.13 (3) equivalent to the standard fare for unassisted transport when provided by public  
13.14 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency  
13.15 medical transportation provider;

13.16 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

13.17 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

13.18 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

13.19 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for  
13.20 an additional attendant if deemed medically necessary.

13.21 (n) The base rate for nonemergency medical transportation services in areas defined  
13.22 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in  
13.23 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation  
13.24 services in areas defined under RUCA to be rural or super rural areas is:

13.25 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage  
13.26 rate in paragraph (m), clauses (1) to (7); and

13.27 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage  
13.28 rate in paragraph (m), clauses (1) to (7).

13.29 (o) For purposes of reimbursement rates for nonemergency medical transportation  
13.30 services under paragraphs (m) and (n), the zip code of the recipient's place of residence  
13.31 shall determine whether the urban, rural, or super rural reimbursement rate applies.

14.1 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means  
14.2 a census-tract based classification system under which a geographical area is determined  
14.3 to be urban, rural, or super rural.

14.4 (q) The commissioner, when determining reimbursement rates for nonemergency medical  
14.5 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed  
14.6 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2)."

14.7 Page 110, delete section 140 and insert:

14.8 "Sec. 140. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is  
14.9 amended to read:

14.10 Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance  
14.11 covers services provided by a community emergency medical technician (CEMT) who is  
14.12 certified under section 144E.275, subdivision 7, when the services are provided in accordance  
14.13 with this subdivision.

14.14 (b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled  
14.15 nursing facility, when ordered by a treating physician or advanced practice registered nurse.  
14.16 The postdischarge visit includes:

14.17 (1) verbal or visual reminders of discharge orders;

14.18 (2) recording and reporting of vital signs to the patient's primary care provider;

14.19 (3) medication access confirmation;

14.20 (4) food access confirmation; and

14.21 (5) identification of home hazards.

14.22 (c) An individual who has repeat ambulance calls due to falls or has been identified by  
14.23 the individual's primary care provider as at risk for nursing home placement, may receive  
14.24 a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance  
14.25 with the individual's care plan. A safety evaluation visit includes:

14.26 (1) medication access confirmation;

14.27 (2) food access confirmation; and

14.28 (3) identification of home hazards.

14.29 (d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit  
14.30 may not be billed for the same day as a postdischarge visit for the same individual."

15.1 Page 120, delete section 148 and insert:

15.2 "Sec. 148. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is  
15.3 amended to read:

15.4 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must  
15.5 meet the following requirements:

15.6 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of  
15.7 age with these additional requirements:

15.8 (i) supervision by a qualified professional every 60 days; and

15.9 (ii) employment by only one personal care assistance provider agency responsible for  
15.10 compliance with current labor laws;

15.11 (2) be employed by a personal care assistance provider agency;

15.12 (3) enroll with the department as a personal care assistant after clearing a background  
15.13 study. Except as provided in subdivision 11a, before a personal care assistant provides  
15.14 services, the personal care assistance provider agency must initiate a background study on  
15.15 the personal care assistant under chapter 245C, and the personal care assistance provider  
15.16 agency must have received a notice from the commissioner that the personal care assistant  
15.17 is:

15.18 (i) not disqualified under section 245C.14; or

15.19 (ii) disqualified, but the personal care assistant has received a set aside of the  
15.20 disqualification under section 245C.22;

15.21 (4) be able to effectively communicate with the recipient and personal care assistance  
15.22 provider agency;

15.23 (5) be able to provide covered personal care assistance services according to the recipient's  
15.24 personal care assistance care plan, respond appropriately to recipient needs, and report  
15.25 changes in the recipient's condition to the supervising qualified professional ~~or~~ physician,  
15.26 or advanced practice registered nurse;

15.27 (6) not be a consumer of personal care assistance services;

15.28 (7) maintain daily written records including, but not limited to, time sheets under  
15.29 subdivision 12;

15.30 (8) effective January 1, 2010, complete standardized training as determined by the  
15.31 commissioner before completing enrollment. The training must be available in languages

16.1 other than English and to those who need accommodations due to disabilities. Personal care  
 16.2 assistant training must include successful completion of the following training components:  
 16.3 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic  
 16.4 roles and responsibilities of personal care assistants including information about assistance  
 16.5 with lifting and transfers for recipients, emergency preparedness, orientation to positive  
 16.6 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the  
 16.7 training components, the personal care assistant must demonstrate the competency to provide  
 16.8 assistance to recipients;

16.9 (9) complete training and orientation on the needs of the recipient; and

16.10 (10) be limited to providing and being paid for up to 275 hours per month of personal  
 16.11 care assistance services regardless of the number of recipients being served or the number  
 16.12 of personal care assistance provider agencies enrolled with. The number of hours worked  
 16.13 per day shall not be disallowed by the department unless in violation of the law.

16.14 (b) A legal guardian may be a personal care assistant if the guardian is not being paid  
 16.15 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

16.16 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,  
 16.17 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care  
 16.18 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of  
 16.19 a residential setting.

16.20 (d) Personal care assistance services qualify for the enhanced rate described in subdivision  
 16.21 17a if the personal care assistant providing the services:

16.22 (1) provides covered services to a recipient who qualifies for 12 or more hours per day  
 16.23 of personal care assistance services; and

16.24 (2) satisfies the current requirements of Medicare for training and competency or  
 16.25 competency evaluation of home health aides or nursing assistants, as provided in the Code  
 16.26 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved  
 16.27 training or competency requirements."

16.28 Page 121, delete section 149 and insert:

16.29 "Sec. 149. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is  
 16.30 amended to read:

16.31 Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The  
 16.32 case manager shall implement the coordinated service and support plan for each alternative



17.1 care client and ensure that a client's service needs and eligibility are reassessed at least every  
17.2 12 months. The coordinated service and support plan must meet the requirements in section  
17.3 256S.10. The plan shall include any services prescribed by the individual's attending  
17.4 physician or advanced practice registered nurse as necessary to allow the individual to  
17.5 remain in a community setting. In developing the individual's care plan, the case manager  
17.6 should include the use of volunteers from families and neighbors, religious organizations,  
17.7 social clubs, and civic and service organizations to support the formal home care services.  
17.8 The lead agency shall be held harmless for damages or injuries sustained through the use  
17.9 of volunteers under this subdivision including workers' compensation liability. The case  
17.10 manager shall provide documentation in each individual's plan and, if requested, to the  
17.11 commissioner that the most cost-effective alternatives available have been offered to the  
17.12 individual and that the individual was free to choose among available qualified providers,  
17.13 both public and private, including qualified case management or service coordination  
17.14 providers other than those employed by any county; however, the county or tribe maintains  
17.15 responsibility for prior authorizing services in accordance with statutory and administrative  
17.16 requirements. The case manager must give the individual a ten-day written notice of any  
17.17 denial, termination, or reduction of alternative care services.

17.18 (b) The county of service or tribe must provide access to and arrange for case management  
17.19 services, including assuring implementation of the coordinated service and support plan.  
17.20 "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart  
17.21 11. The county of service must notify the county of financial responsibility of the approved  
17.22 care plan and the amount of encumbered funds."

17.23 Page 124, delete section 152 and insert:

17.24 "Sec. 152. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

17.25 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**  
17.26 **NECESSITY.**

17.27 (a) The amount paid for a private room is 111.5 percent of the established total payment  
17.28 rate for a resident if the resident is a medical assistance recipient and the private room is  
17.29 considered a medical necessity for the resident or others who are affected by the resident's  
17.30 condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C.  
17.31 Conditions requiring a private room must be determined by the resident's attending physician  
17.32 or advanced practice registered nurse and submitted to the commissioner for approval or  
17.33 denial by the commissioner on the basis of medical necessity.

18.1 (b) For a nursing facility with a total property payment rate determined under section  
 18.2 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established  
 18.3 total payment rate for a resident if the resident is a medical assistance recipient and the  
 18.4 private room is considered a medical necessity for the resident or others who are affected  
 18.5 by the resident's condition. Conditions requiring a private room must be determined by the  
 18.6 resident's attending physician or advanced practice registered nurse and submitted to the  
 18.7 commissioner for approval or denial by the commissioner on the basis of medical necessity."

18.8 Page 126, after line 25, insert:

18.9 "Sec. 160. **REPEALER.**

18.10 Minnesota Rules, part 9505.0365, subpart 3, is repealed."

18.11 Renumber the sections in sequence

18.12 Correct the title numbers accordingly

18.13 With the recommendation that when so amended the bill be returned to the Committee  
 18.14 on Ways and Means.

18.15 This Division action taken March 11, 2020

18.16 ....., Chair