

1.1 moves to amend H.F. No. 3727 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 DEPARTMENT OF HEALTH

1.5 Section 1. Minnesota Statutes 2018, section 144.121, subdivision 1, is amended to read:

1.6 Subdivision 1. **Registration; fees.** The fee for the registration for x-ray ~~machines~~
1.7 equipment and other sources of ionizing radiation required to be registered under rules
1.8 adopted by the state commissioner of health pursuant to section 144.12, shall be in an amount
1.9 as described in subdivision 1a pursuant to section 144.122. The registration shall expire and
1.10 be renewed as prescribed by the commissioner pursuant to section 144.122.

1.11 Sec. 2. Minnesota Statutes 2019 Supplement, section 144.121, subdivision 1a, is amended
1.12 to read:

1.13 Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing
1.14 radiation-producing equipment and other sources of ionizing radiation must pay an ~~annual~~
1.15 initial or annual renewal registration fee consisting of a base facility fee of \$100 and an
1.16 additional fee for each ~~radiation source~~ x-ray tube, as follows:

- 1.17 (1) medical or veterinary equipment \$ 100
- 1.18 (2) dental x-ray equipment \$ 40
- 1.19 (3) x-ray equipment not used on \$ 100
- 1.20 humans or animals
- 1.21 (4) devices with sources of ionizing \$ 100
- 1.22 radiation not used on humans or
- 1.23 animals
- 1.24 (5) security screening system \$ 100

2.1 (b) A facility with radiation therapy and accelerator equipment must pay an initial or
2.2 annual registration fee of \$500. A facility with an industrial accelerator must pay an initial
2.3 or annual registration fee of \$150.

2.4 (c) Electron microscopy equipment is exempt from the registration fee requirements of
2.5 this section.

2.6 (d) For purposes of this section, a security screening system means ionizing
2.7 radiation-producing equipment designed and used for security screening of humans who
2.8 are in the custody of a correctional or detention facility, and used by the facility to image
2.9 and identify contraband items concealed within or on all sides of a human body. For purposes
2.10 of this section, a correctional or detention facility is a facility licensed under section 241.021
2.11 and operated by a state agency or political subdivision charged with detection, enforcement,
2.12 or incarceration in respect to state criminal and traffic laws.

2.13 Sec. 3. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to
2.14 read:

2.15 Subd. 1d. **Handheld dental x-ray equipment.** A facility that uses handheld dental x-ray
2.16 equipment according to section 144.1215 must comply with this section.

2.17 Sec. 4. Minnesota Statutes 2018, section 144.121, subdivision 2, is amended to read:

2.18 Subd. 2. **Inspections.** Periodic radiation safety inspections of the x-ray equipment and
2.19 other sources of ionizing radiation shall be made by the ~~state~~ commissioner of health. The
2.20 frequency of safety inspections shall be prescribed by the commissioner on the basis of the
2.21 frequency of use of the x-ray equipment and other source of ionizing radiation; provided
2.22 that each source shall be inspected at least once every four years.

2.23 Sec. 5. Minnesota Statutes 2018, section 144.121, subdivision 5, is amended to read:

2.24 Subd. 5. **Examination for individual operating x-ray equipment systems.** (a) ~~After~~
2.25 ~~January 1, 2008,~~ An individual in a facility with x-ray equipment systems for use on living
2.26 humans that is registered under subdivision 1 may not operate, nor may the facility allow
2.27 the individual to operate, x-ray equipment systems unless the individual has passed a national
2.28 or state examination ~~for limited x-ray machine operators that meets the requirements of~~
2.29 ~~paragraphs (b) and (c) and is approved by the commissioner of health.~~

2.30 (b) ~~The commissioner shall establish criteria for the approval of examinations based on~~
2.31 ~~national standards, such as the examination in radiography from the American Registry of~~
2.32 ~~Radiologic Technologists, the examination for limited scope of practice in radiography from~~

3.1 ~~the American Registry of Radiologic Technologists for limited x-ray machine operators,~~
3.2 ~~and the American Registry of Chiropractic Radiography Technologists for limited~~
3.3 ~~radiography in spines and extremities; or equivalent examinations approved by other states.~~
3.4 ~~Equivalent examinations may be approved by the commissioner, if the examination is~~
3.5 ~~consistent with the standards for educational and psychological testing as recommended by~~
3.6 ~~the American Education Research Association, the American Psychological Association,~~
3.7 ~~the National Council on Measurement in Education, or the National Commission for~~
3.8 ~~Certifying Agencies. The organization proposing the use of an equivalent examination shall~~
3.9 ~~submit a fee to the commissioner of \$1,000 per examination to cover the cost of determining~~
3.10 ~~the extent to which the examination meets the examining standards. The collected fee shall~~
3.11 ~~be deposited in the state treasury and credited to the state government special revenue fund.~~

3.12 (b) Individuals who may operate x-ray systems include:

3.13 (1) an individual who has passed the American Registry of Radiologic Technologists
3.14 (ARRT) registry for radiography examination;

3.15 (2) an individual who has passed the American Chiropractic Registry of Radiologic
3.16 Technologists (ACRRT) registry examination and is limited to radiography of spines and
3.17 extremities;

3.18 (3) a registered limited scope x-ray operator and a registered bone densitometry equipment
3.19 operator who passed the examination requirements in paragraphs (d) and (e) and practices
3.20 according to subdivision 5a;

3.21 (4) an x-ray operator who has the original certificate or the original letter of passing the
3.22 examination that was required before January 1, 2008, under Minnesota Statutes 2008,
3.23 section 144.121, subdivision 5a, paragraph (b), clause (1);

3.24 (5) an individual who has passed the American Registry of Radiologic Technologists
3.25 (ARRT) registry for radiation therapy examination according to subdivision 5e;

3.26 (6) a cardiovascular technologist according to subdivision 5c;

3.27 (7) a nuclear medicine technologist according to subdivision 5d;

3.28 (8) an individual who has passed the examination for a dental hygienist under section
3.29 150A.06 and only operates dental x-ray systems;

3.30 (9) an individual who has passed the examination for a dental therapist under section
3.31 150A.06 and only operates dental x-ray systems;

4.1 (10) an individual who has passed the examination for a dental assistant under section
 4.2 150A.06, and only operates dental x-ray systems;

4.3 (11) an individual who has passed the examination under Minnesota Rules, part
 4.4 3100.8500, subpart 3, and only operates dental x-ray systems; and

4.5 (12) a qualified practitioner who is licensed by a health-related licensing board with
 4.6 active practice authority and is working within the practitioner's scope of practice.

4.7 (c) Except for individuals under clauses (3) and (4), an individual who is participating
 4.8 in a training or educational program in any of the occupations listed in paragraph (b) is
 4.9 exempt from the examination requirement within the scope and for the duration of the
 4.10 training or educational program.

4.11 ~~(e)~~ (d) The Minnesota examination for limited scope x-ray machine operators must
 4.12 include:

4.13 (1) radiation protection, radiation physics and radiobiology, equipment maintenance and
 4.14 operation and quality assurance, image production acquisition and technical evaluation, and
 4.15 patient care interactions and management; and

4.16 (2) at least one of the following regions of the human anatomy: chest, extremities, skull
 4.17 and sinus, spine, or ankle and foot podiatry. The examinations must include the anatomy
 4.18 of, and positioning radiographic positions and projections for, the specific regions.

4.19 (e) The examination for bone densitometry equipment operators must include:

4.20 (1) osteoporosis, bone physiology, bone health and patient education, patient preparation,
 4.21 fundamental principals, biological effects of radiation, units of measurements, radiation
 4.22 protection in bone densitometry, fundamentals of x-ray production, quality control, measuring
 4.23 bone mineral testing, determining quality in bone mineral testing, file and database
 4.24 management; and

4.25 (2) dual x-ray absorptiometry scanning of the lumbar spine, proximal femur, and forearm.
 4.26 The examination must include the anatomy, scan acquisition, and scan analysis for these
 4.27 three procedures.

4.28 ~~(d)~~ (f) A limited scope x-ray operator, and a bone densitometry equipment operator,
 4.29 who is are required to take an examination under this subdivision must submit to the
 4.30 commissioner an a registration application for the examination; and a \$25 processing fee;
 4.31 and the required examination fee set by the national organization offering the examination.
 4.32 The processing fee and the examination fee shall be deposited in the state treasury and

5.1 credited to the state government special revenue fund. ~~The commissioner shall submit the~~
5.2 ~~fee to the national organization providing the examination.~~

5.3 Sec. 6. Minnesota Statutes 2019 Supplement, section 144.121, subdivision 5a, is amended
5.4 to read:

5.5 Subd. 5a. **Limited scope x-ray machine and bone densitometry equipment operator**
5.6 **practice.** ~~(a) A registered limited scope x-ray operator and a registered bone densitometry~~
5.7 ~~equipment operator may only practice medical radiography on limited regions of the human~~
5.8 ~~anatomy for which the operator has successfully passed an examination identified in~~
5.9 ~~subdivision 5, unless the operator meets one of the exemptions described in paragraph (b).~~
5.10 ~~The operator may practice using only routine radiographic procedures, for the interpretation~~
5.11 ~~by and under the direction of a qualified practitioner, excluding paragraphs (d) and (e) and~~
5.12 ~~may not operate computed tomography, cone beam computed tomography, the use of contrast~~
5.13 ~~media, and the use of fluoroscopic or mammographic equipment x-ray systems.~~

5.14 ~~(b) This subdivision does not apply to:~~

5.15 ~~(1) limited x-ray machine operators who passed the examination that was required before~~
5.16 ~~January 1, 2008;~~

5.17 ~~(2) certified radiologic technologists, licensed dental hygienists, registered dental~~
5.18 ~~assistants, certified registered nurse anesthetists, and registered physician assistants;~~

5.19 ~~(3) individuals who are licensed in Minnesota to practice medicine, osteopathic medicine,~~
5.20 ~~chiropractic, podiatry, or dentistry;~~

5.21 ~~(4) individuals who are participating in a training course in any of the occupations listed~~
5.22 ~~in clause (2), (3), or (5) for the duration and within the scope of the training course; and~~

5.23 ~~(5) cardiovascular technologists who assist with the operation of fluoroscopy equipment~~
5.24 ~~if they:~~

5.25 ~~(i) are credentialed by Cardiovascular Credentialing International as a registered~~
5.26 ~~cardiovascular invasive specialist or as a registered cardiac electrophysiology specialist,~~
5.27 ~~are a graduate of an education program accredited by the Commission on Accreditation of~~
5.28 ~~Allied Health Education Programs, which uses the standards and criteria established by the~~
5.29 ~~Joint Review Committee on Education in Cardiovascular Technology, or are designated on~~
5.30 ~~a variance granted by the commissioner, effective July 31, 2019; and~~

5.31 ~~(ii) are under the personal supervision and in the physical presence of a qualified~~
5.32 ~~practitioner for diagnosing or treating a disease or condition of the cardiovascular system~~

6.1 ~~in fluoroscopically guided interventional procedures. Cardiovascular technologists may not~~
6.2 ~~activate the fluoroscopic system or evaluate quality control tests.~~

6.3 Sec. 7. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to
6.4 read:

6.5 Subd. 5c. **Cardiovascular technologist practice.** (a) Cardiovascular technologists may
6.6 assist with the operation of fluoroscopy equipment if they:

6.7 (1) are credentialed by Cardiovascular Credentialing International as a registered
6.8 cardiovascular invasive specialist or as a registered cardiac electrophysiology specialist,
6.9 are a graduate of an educational program accredited by the Commission on Accreditation
6.10 of Allied Health Education Programs, which uses the standards and criteria established by
6.11 the Joint Review Committee on Education in Cardiovascular Technology, or are designated
6.12 on a variance granted by the commissioner effective July 31, 2019; and

6.13 (2) are under the personal supervision and in the physical presence of a qualified
6.14 practitioner for diagnosing or treating a disease or condition of the cardiovascular system
6.15 in fluoroscopically guided interventional procedures. Cardiovascular technologists may not
6.16 activate the fluoroscopic system or evaluate quality control tests.

6.17 (b) A cardiovascular technologist who is participating in a training or educational program
6.18 in any of the occupations listed in this subdivision is exempt from the examination
6.19 requirement within the scope and for the duration of the training or educational program.

6.20 Sec. 8. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to
6.21 read:

6.22 Subd. 5d. **Nuclear medicine technologist practice.** (a) Nuclear medicine technologists
6.23 who have passed the primary pathway credential in Nuclear Medicine Technology
6.24 Certification Board (NMTCB) for nuclear medicine or the American Registry of Radiologic
6.25 Technologists (ARRT) for nuclear medicine technology or the American Society of Clinical
6.26 Pathologists (NM) (ASCP) may operate a fusion imaging device or a dual imaging device
6.27 that uses radioactive material as a point source in transmission scanning and attenuation
6.28 correction.

6.29 (b) A nuclear medicine technologist in paragraph (a) may only operate a stand-alone
6.30 computed tomography x-ray system if the technologist has passed the Nuclear Medicine
6.31 Technology Certification Board for computed tomography (CT) or is credentialed in

7.1 computed tomography (CT) from the American Registry of Radiologic Technologists
7.2 (ARRT).

7.3 (c) A nuclear medicine technologist who meets the requirements under paragraph (a)
7.4 and who is participating in a training or educational program to obtain a credential under
7.5 paragraph (b) is exempt from the examination requirement within the scope and for the
7.6 duration of the training or educational program.

7.7 Sec. 9. Minnesota Statutes 2018, section 144.121, is amended by adding a subdivision to
7.8 read:

7.9 Subd. 5e. **Radiation therapy technologist practice.** (a) A radiation therapy technologist
7.10 who has passed the primary pathway credential in radiation therapy may operate radiation
7.11 therapy accelerator and simulator x-ray systems.

7.12 (b) A radiation therapy technologist in paragraph (a) may only operate a stand-alone
7.13 computed tomography x-ray system if the technologist has passed and is credentialed in
7.14 computed tomography (CT) from the American Registry of Radiologic Technologists
7.15 (ARRT).

7.16 (c) A radiation therapy technologist who meets the requirements under paragraph (a)
7.17 and who is participating in a training or educational program to obtain a credential under
7.18 paragraph (b) is exempt from the examination requirement within the scope and for the
7.19 duration of the training or educational program.

7.20 Sec. 10. Minnesota Statutes 2018, section 144.292, subdivision 2, is amended to read:

7.21 Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient within 30
7.22 calendar days of receiving a written request for medical records complete and current
7.23 information possessed by that provider concerning any diagnosis, treatment, and prognosis
7.24 of the patient in terms and language the patient can reasonably be expected to understand.

7.25 Sec. 11. Minnesota Statutes 2018, section 144.292, subdivision 5, is amended to read:

7.26 Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296,
7.27 upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly
7.28 furnish to the patient within 30 calendar days of receiving a written request for medical
7.29 records:

8.1 (1) copies of the patient's health record, including but not limited to laboratory reports,
8.2 x-rays, prescriptions, and other technical information used in assessing the patient's health
8.3 conditions; or

8.4 (2) the pertinent portion of the record relating to a condition specified by the patient.

8.5 With the consent of the patient, the provider may instead furnish only a summary of the
8.6 record. The provider may exclude from the health record written speculations about the
8.7 patient's health condition, except that all information necessary for the patient's informed
8.8 consent must be provided.

8.9 Sec. 12. Minnesota Statutes 2019 Supplement, section 152.29, subdivision 1, is amended
8.10 to read:

8.11 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer ~~shall~~ may operate
8.12 eight distribution facilities, which may include the manufacturer's single location for
8.13 cultivation, harvesting, manufacturing, packaging, and processing but is not required to
8.14 include that location. The commissioner shall designate the geographical service areas to
8.15 be served by each manufacturer based on geographical need throughout the state to improve
8.16 patient access. A manufacturer shall not have more than two distribution facilities in each
8.17 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
8.18 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
8.19 and processing of medical cannabis shall be conducted. This location may be one of the
8.20 manufacturer's distribution facility sites. The additional distribution facilities may dispense
8.21 medical cannabis and medical cannabis products but may not contain any medical cannabis
8.22 in a form other than those forms allowed under section 152.22, subdivision 6, and the
8.23 manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or
8.24 processing at the other distribution facility sites. Any distribution facility operated by the
8.25 manufacturer is subject to all of the requirements applying to the manufacturer under sections
8.26 152.22 to 152.37, including, but not limited to, security and distribution requirements.

8.27 (b) A manufacturer may acquire hemp grown in this state from a hemp grower. A
8.28 manufacturer may manufacture or process hemp into an allowable form of medical cannabis
8.29 under section 152.22, subdivision 6. Hemp acquired by a manufacturer under this paragraph
8.30 is subject to the same quality control program, security and testing requirements, and other
8.31 requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota
8.32 Rules, chapter 4770.

8.33 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
8.34 commissioner, subject to any additional requirements set by the commissioner, for purposes

9.1 of testing medical cannabis manufactured or hemp acquired by the medical cannabis
9.2 manufacturer as to content, contamination, and consistency to verify the medical cannabis
9.3 meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall
9.4 be paid by the manufacturer.

9.5 (d) The operating documents of a manufacturer must include:

9.6 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
9.7 record keeping;

9.8 (2) procedures for the implementation of appropriate security measures to deter and
9.9 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
9.10 cannabis; and

9.11 (3) procedures for the delivery and transportation of hemp between hemp growers and
9.12 manufacturers.

9.13 (e) A manufacturer shall implement security requirements, including requirements for
9.14 the delivery and transportation of hemp, protection of each location by a fully operational
9.15 security alarm system, facility access controls, perimeter intrusion detection systems, and
9.16 a personnel identification system.

9.17 (f) A manufacturer shall not share office space with, refer patients to a health care
9.18 practitioner, or have any financial relationship with a health care practitioner.

9.19 (g) A manufacturer shall not permit any person to consume medical cannabis on the
9.20 property of the manufacturer.

9.21 (h) A manufacturer is subject to reasonable inspection by the commissioner.

9.22 (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not
9.23 subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

9.24 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
9.25 of age or who has been convicted of a disqualifying felony offense. An employee of a
9.26 medical cannabis manufacturer must submit a completed criminal history records check
9.27 consent form, a full set of classifiable fingerprints, and the required fees for submission to
9.28 the Bureau of Criminal Apprehension before an employee may begin working with the
9.29 manufacturer. The bureau must conduct a Minnesota criminal history records check and
9.30 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
9.31 Investigation to obtain the applicant's national criminal history record information. The
9.32 bureau shall return the results of the Minnesota and federal criminal history records checks
9.33 to the commissioner.

10.1 (k) A manufacturer may not operate in any location, whether for distribution or
10.2 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
10.3 public or private school existing before the date of the manufacturer's registration with the
10.4 commissioner.

10.5 (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
10.6 relating to signage, marketing, display, and advertising of medical cannabis.

10.7 (m) Before a manufacturer acquires hemp from a hemp grower, the manufacturer must
10.8 verify that the hemp grower has a valid license issued by the commissioner of agriculture
10.9 under chapter 18K.

10.10 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
10.11 medical cannabis plant from cultivation through testing and point of sale, the commissioner
10.12 shall conduct at least one unannounced inspection per year of each manufacturer that includes
10.13 inspection of:

10.14 (1) business operations;

10.15 (2) physical locations of the manufacturer's manufacturing facility and distribution
10.16 facilities;

10.17 (3) financial information and inventory documentation, including laboratory testing
10.18 results; and

10.19 (4) physical and electronic security alarm systems.

10.20 Sec. 13. Minnesota Statutes 2018, section 152.35, is amended to read:

10.21 **152.35 FEES; DEPOSIT OF REVENUE.**

10.22 (a) The commissioner shall collect an enrollment fee of \$200 from patients enrolled
10.23 under this section. If the patient ~~attests to~~ provides evidence of receiving Social Security
10.24 disability insurance (SSDI), Supplemental Security Insurance Income (SSI), veterans
10.25 disability, or railroad disability payments, or being enrolled in medical assistance or
10.26 MinnesotaCare, then the fee shall be \$50. For purposes of this section:

10.27 (1) a patient is considered to receive SSDI if the patient was receiving SSDI at the time
10.28 the patient was transitioned to retirement benefits by the United States Social Security
10.29 Administration; and

10.30 (2) veterans disability payments include VA dependency and indemnity compensation.

11.1 Unless a patient provides evidence of receiving payments from or participating in one of
11.2 the programs specifically listed in this paragraph, the commissioner of health must collect
11.3 the \$200 enrollment fee from a patient to enroll the patient in the registry program. The fees
11.4 shall be payable annually and are due on the anniversary date of the patient's enrollment.
11.5 The fee amount shall be deposited in the state treasury and credited to the state government
11.6 special revenue fund.

11.7 (b) The commissioner shall collect an application fee of \$20,000 from each entity
11.8 submitting an application for registration as a medical cannabis manufacturer. Revenue
11.9 from the fee shall be deposited in the state treasury and credited to the state government
11.10 special revenue fund.

11.11 (c) The commissioner shall establish and collect an annual fee from a medical cannabis
11.12 manufacturer equal to the cost of regulating and inspecting the manufacturer in that year.
11.13 Revenue from the fee amount shall be deposited in the state treasury and credited to the
11.14 state government special revenue fund.

11.15 (d) A medical cannabis manufacturer may charge patients enrolled in the registry program
11.16 a reasonable fee for costs associated with the operations of the manufacturer. The
11.17 manufacturer may establish a sliding scale of patient fees based upon a patient's household
11.18 income and may accept private donations to reduce patient fees.

11.19 Sec. 14. Laws 2019, First Special Session chapter 9, article 11, section 35, the effective
11.20 date, is amended to read:

11.21 **EFFECTIVE DATE.** This section is effective ~~August 1, 2020~~ January 1, 2021.

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

11.23 Sec. 15. **REPEALER.**

11.24 Minnesota Statutes 2018, section 144.121, subdivisions 3 and 5b, are repealed.

11.25 **ARTICLE 2**

11.26 **HEALTH RELATED LICENSING BOARDS**

11.27 Section 1. Minnesota Statutes 2018, section 62A.307, subdivision 2, is amended to read:

11.28 Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription
11.29 drugs must provide the same coverage for a prescription written by a health care provider
11.30 authorized to prescribe the particular drug covered by the health coverage described in
11.31 subdivision 1, regardless of the type of health care provider that wrote the prescription. This

12.1 section is intended to prohibit denial of coverage based on the prescription having been
12.2 written by an advanced practice nurse under section 148.235, a physician assistant under
12.3 section ~~147A.18~~ 147A.185, or any other nonphysician health care provider authorized to
12.4 prescribe the particular drug.

12.5 Sec. 2. **[62Q.529] COVERAGE FOR DRUGS PRESCRIBED AND DISPENSED BY**
12.6 **PHARMACIES.**

12.7 (a) A health plan that provides prescription coverage must provide coverage for
12.8 self-administered hormonal contraceptives, nicotine replacement medications, and opiate
12.9 antagonists for the treatment of an acute opiate overdose prescribed and dispensed by a
12.10 licensed pharmacist in accordance with section 151.37, subdivision 14, 15, or 16, under the
12.11 same terms of coverage that would apply had the prescription drug been prescribed by a
12.12 licensed physician, physician assistant, or advanced practice nurse practitioner.

12.13 (b) A health plan is not required to cover the drug if dispensed by an out-of-network
12.14 pharmacy, unless the health plan covers prescription drugs dispensed by out-of-network
12.15 pharmacies.

12.16 Sec. 3. Minnesota Statutes 2018, section 147A.01, subdivision 3, is amended to read:

12.17 Subd. 3. **Administer.** "Administer" means the delivery by a physician assistant ~~authorized~~
12.18 ~~to prescribe legend drugs, a single dose of a legend drug, including controlled substances,~~
12.19 ~~to a patient by injection, inhalation, ingestion, or by any other immediate means, and the~~
12.20 ~~delivery by a physician assistant ordered by a physician a single dose of a legend drug by~~
12.21 ~~injection, inhalation, ingestion, or by any other immediate means.~~

12.22 Sec. 4. Minnesota Statutes 2018, section 147A.01, is amended by adding a subdivision to
12.23 read:

12.24 Subd. 6a. **Collaborating physician.** "Collaborating physician" means a Minnesota
12.25 licensed physician who oversees the performance, practice, and activities of a physician
12.26 assistant under a collaborative agreement as described in section 147A.02, paragraph (c).

12.27 Sec. 5. Minnesota Statutes 2018, section 147A.01, subdivision 21, is amended to read:

12.28 Subd. 21. **Prescription.** "Prescription" means a signed written order, an oral order
12.29 reduced to writing, or an electronic order meeting current and prevailing standards given
12.30 by a physician assistant ~~authorized to prescribe drugs~~ for patients in the course of the

13.1 physician assistant's practice, and issued for an individual patient ~~and containing the~~
13.2 ~~information required in the physician-physician assistant delegation agreement.~~

13.3 Sec. 6. Minnesota Statutes 2018, section 147A.01, subdivision 26, is amended to read:

13.4 Subd. 26. **Therapeutic order.** "Therapeutic order" means ~~an~~ a written or verbal order
13.5 given to another for the purpose of treating or curing a patient in the course of a physician
13.6 assistant's practice. ~~Therapeutic orders may be written or verbal, but do not include the~~
13.7 ~~prescribing of legend drugs or medical devices unless prescribing authority has been~~
13.8 ~~delegated within the physician-physician assistant delegation agreement.~~

13.9 Sec. 7. Minnesota Statutes 2018, section 147A.01, subdivision 27, is amended to read:

13.10 Subd. 27. **Verbal order.** "Verbal order" means an oral order given to another for the
13.11 purpose of treating or curing a patient in the course of a physician assistant's practice. ~~Verbal~~
13.12 ~~orders do not include the prescribing of legend drugs unless prescribing authority has been~~
13.13 ~~delegated within the physician-physician assistant delegation agreement.~~

13.14 Sec. 8. Minnesota Statutes 2018, section 147A.02, is amended to read:

13.15 **147A.02 QUALIFICATIONS FOR LICENSURE.**

13.16 ~~Except as otherwise provided in this chapter, an individual shall be licensed by the board~~
13.17 ~~before the individual may practice as a physician assistant.~~

13.18 (a) The board may grant a license as a physician assistant to an applicant who:

13.19 (1) submits an application on forms approved by the board;

13.20 (2) pays the appropriate fee as determined by the board;

13.21 (3) has current certification from the National Commission on Certification of Physician
13.22 Assistants, or its successor agency as approved by the board;

13.23 (4) certifies that the applicant is mentally and physically able to engage safely in practice
13.24 as a physician assistant;

13.25 (5) has no licensure, certification, or registration as a physician assistant under current
13.26 discipline, revocation, suspension, or probation for cause resulting from the applicant's
13.27 practice as a physician assistant, unless the board considers the condition and agrees to
13.28 licensure;

13.29 (6) submits any other information the board deems necessary to evaluate the applicant's
13.30 qualifications; and

14.1 (7) has been approved by the board.

14.2 (b) All persons registered as physician assistants as of June 30, 1995, are eligible for
14.3 continuing license renewal. All persons applying for licensure after that date shall be licensed
14.4 according to this chapter.

14.5 (c) A physician assistant who qualifies for licensure must practice for at least 2,080
14.6 hours, within the context of a collaborative agreement, within a hospital or integrated clinical
14.7 setting where physician assistants and physicians work together to provide patient care. The
14.8 physician assistant shall submit written evidence to the board with the application, or upon
14.9 completion of the required collaborative practice experience. For purposes of this paragraph,
14.10 a collaborative agreement is a mutually agreed upon plan for the overall working relationship
14.11 and collaborative arrangement between a physician assistant, and one or more physicians
14.12 licensed under chapter 147, that designates the scope of services that can be provided to
14.13 manage the care of patients. The physician assistant and one of the collaborative physicians
14.14 must have experience in providing care to patients with the same or similar medical
14.15 conditions. The collaborating physician is not required to be physically present so long as
14.16 the collaborating physician and physician assistant are or can be easily in contact with each
14.17 other by radio, telephone, or other telecommunication device.

14.18 Sec. 9. Minnesota Statutes 2018, section 147A.03, is amended by adding a subdivision to
14.19 read:

14.20 Subd. 1a. **Licensure required.** Except as provided under subdivision 2, it is unlawful
14.21 for any person to practice as a physician assistant without being issued a valid license
14.22 according to this chapter.

14.23 Sec. 10. Minnesota Statutes 2018, section 147A.05, is amended to read:

14.24 **147A.05 INACTIVE LICENSE.**

14.25 (a) Physician assistants who notify the board in writing may elect to place their license
14.26 on an inactive status. Physician assistants with an inactive license shall be excused from
14.27 payment of renewal fees and shall not practice as physician assistants. Persons who engage
14.28 in practice while their license is lapsed or on inactive status shall be considered to be
14.29 practicing without a license, which shall be grounds for discipline under section 147A.13.
14.30 Physician assistants who provide care under the provisions of section 147A.23 shall not be
14.31 considered practicing without a license or subject to disciplinary action. Physician assistants
14.32 who notify the board of their intent to resume active practice shall be required to pay the

15.1 current renewal fees and all unpaid back fees and shall be required to meet the criteria for
15.2 renewal specified in section 147A.07.

15.3 (b) Notwithstanding section 147A.03, subdivision 1, a person with an inactive license
15.4 may continue to use the protected titles specified in section 147A.03, subdivision 1, so long
15.5 as the person does not practice as a physician assistant.

15.6 Sec. 11. Minnesota Statutes 2019 Supplement, section 147A.06, is amended to read:

15.7 **147A.06 CANCELLATION OF LICENSE FOR NONRENEWAL.**

15.8 Subdivision 1. **Cancellation of license.** The board shall not renew, reissue, reinstate, or
15.9 restore a license that has lapsed ~~on or after July 1, 1996,~~ and has not been renewed within
15.10 two annual renewal cycles ~~starting July 1, 1997.~~ A licensee whose license is canceled for
15.11 nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements
15.12 then in existence for an initial license to practice as a physician assistant.

15.13 Subd. 2. **Licensure following lapse of licensed status; transition.** (a) A licensee whose
15.14 license has lapsed under subdivision 1 before January 1, 2020, and who seeks to regain
15.15 licensed status after January 1, 2020, shall be treated as a first-time licensee only for purposes
15.16 of establishing a license renewal schedule, and shall not be subject to the license cycle
15.17 conversion provisions in section 147A.29.

15.18 (b) This subdivision expires July 1, 2022.

15.19 Sec. 12. Minnesota Statutes 2018, section 147A.09, is amended to read:

15.20 **147A.09 SCOPE OF PRACTICE, ~~DELEGATION.~~**

15.21 Subdivision 1. **Scope of practice.** Physician assistants shall practice medicine only ~~with~~
15.22 ~~physician supervision. Physician assistants may perform those duties and responsibilities~~
15.23 ~~as delegated in the physician-physician assistant delegation agreement and delegation forms~~
15.24 ~~maintained at the address of record by the supervising physician and physician assistant,~~
15.25 ~~including the prescribing, administering, and dispensing of drugs, controlled substances,~~
15.26 ~~and medical devices, excluding anesthetics, other than local anesthetics, injected in~~
15.27 ~~connection with an operating room procedure, inhaled anesthesia and spinal anesthesia~~
15.28 under an established practice agreement.

15.29 ~~Patient service must be limited to~~ A physician assistant's scope of practice includes:

15.30 (1) services within the training and experience of the physician assistant;

16.1 (2) patient services customary to the practice of the supervising physician or alternate
16.2 supervising physician physician assistant and the practice agreement; and

16.3 (3) ~~services delegated by the supervising physician or alternate supervising physician~~
16.4 ~~under the physician-physician assistant delegation agreement; and~~

16.5 (4) services within the parameters of the laws, rules, and standards of the facilities in
16.6 which the physician assistant practices.

16.7 ~~Nothing in this chapter authorizes physician assistants to perform duties regulated by~~
16.8 ~~the boards listed in section 214.01, subdivision 2, other than the Board of Medical Practice,~~
16.9 ~~and except as provided in this section.~~

16.10 Subd. 2. **Delegation Patient services.** Patient services may include, but are not limited
16.11 to, the following, ~~as delegated by the supervising physician and authorized in the delegation~~
16.12 ~~agreement:~~

16.13 (1) taking patient histories and developing medical status reports;

16.14 (2) performing physical examinations;

16.15 (3) interpreting and evaluating patient data;

16.16 (4) ordering ~~or~~, performing, or reviewing diagnostic procedures, including the use of
16.17 radiographic imaging systems in compliance with Minnesota Rules 2007, chapter 4732, but
16.18 excluding interpreting computed tomography scans, magnetic resonance imaging scans,
16.19 positron emission tomography scans, nuclear scans, and mammography;

16.20 (5) ordering or performing therapeutic procedures including the use of ionizing radiation
16.21 in compliance with Minnesota Rules 2007, chapter 4732;

16.22 (6) providing instructions regarding patient care, disease prevention, and health
16.23 promotion;

16.24 (7) ~~assisting the supervising physician in~~ providing patient care in the home and in health
16.25 care facilities;

16.26 (8) creating and maintaining appropriate patient records;

16.27 (9) transmitting or executing specific orders ~~at the direction of the supervising physician;~~

16.28 (10) prescribing, administering, and dispensing drugs, controlled substances, and medical
16.29 devices ~~if this function has been delegated by the supervising physician pursuant to and~~
16.30 ~~subject to the limitations of section 147A.18 and chapter 151. For physician assistants who~~
16.31 ~~have been delegated the authority to prescribe controlled substances, such delegation shall~~

17.1 ~~be included in the physician-physician assistant delegation agreement, and all schedules of~~
17.2 ~~controlled substances the physician assistant has the authority to prescribe shall be specified,~~
17.3 ~~and includes administering local anesthetics, but excluding anesthetics injected in connection~~
17.4 ~~with an operating room procedure, inhaled anesthesia, and spinal anesthesia;~~

17.5 ~~(11) for physician assistants not delegated prescribing authority, administering legend~~
17.6 ~~drugs and medical devices following prospective review for each patient by and upon~~
17.7 ~~direction of the supervising physician;~~

17.8 ~~(12) functioning as an emergency medical technician with permission of the ambulance~~
17.9 ~~service and in compliance with section 144E.127, and ambulance service rules adopted by~~
17.10 ~~the commissioner of health;~~

17.11 ~~(13) (12) initiating evaluation and treatment procedures essential to providing an~~
17.12 ~~appropriate response to emergency situations;~~

17.13 ~~(14) (13) certifying a patient's eligibility for a disability parking certificate under section~~
17.14 ~~169.345, subdivision 2;~~

17.15 ~~(15) (14) assisting at surgery; and~~

17.16 ~~(16) (15) providing medical authorization for admission for emergency care and treatment~~
17.17 ~~of a patient under section 253B.05, subdivision 2.~~

17.18 ~~Orders of physician assistants shall be considered the orders of their supervising~~
17.19 ~~physicians in all practice-related activities, including, but not limited to, the ordering of~~
17.20 ~~diagnostic, therapeutic, and other medical services.~~

17.21 Subd. 3. **Practice agreement review.** A physician assistant shall have a practice
17.22 agreement at the practice level that describes the practice of the physician assistant. The
17.23 practice agreement must be reviewed on an annual basis by a licensed physician within the
17.24 same clinic, hospital, health system, or other facility as the physician assistant and has
17.25 knowledge of the physician assistant's practice to ensure that the physician assistant's medical
17.26 practice is consistent with the practice agreement. A document stating that the review
17.27 occurred must be maintained at the practice level and made available to the board, upon
17.28 request.

17.29 Subd. 4. **Scope of practice limitations; spinal injections for acute and chronic**
17.30 **pain.** Notwithstanding subdivision 1, a physician assistant may only perform spinal injections
17.31 to address acute and chronic pain symptoms upon referral and in collaboration with a
17.32 physician licensed under chapter 147. For purposes of performing spinal injections for acute
17.33 or chronic pain symptoms, the physician assistant and one or more physicians licensed under

18.1 chapter 147 must have a mutually agreed upon plan that designates the scope of collaboration
18.2 necessary for treating patients with acute and chronic pain.

18.3 Sec. 13. Minnesota Statutes 2018, section 147A.13, subdivision 1, is amended to read:

18.4 Subdivision 1. **Grounds listed.** The board may refuse to grant licensure or may impose
18.5 disciplinary action as described in this subdivision against any physician assistant. The
18.6 following conduct is prohibited and is grounds for disciplinary action:

18.7 (1) failure to demonstrate the qualifications or satisfy the requirements for licensure
18.8 contained in this chapter or rules of the board. The burden of proof shall be upon the applicant
18.9 to demonstrate such qualifications or satisfaction of such requirements;

18.10 (2) obtaining a license by fraud or cheating, or attempting to subvert the examination
18.11 process. Conduct which subverts or attempts to subvert the examination process includes,
18.12 but is not limited to:

18.13 (i) conduct which violates the security of the examination materials, such as removing
18.14 examination materials from the examination room or having unauthorized possession of
18.15 any portion of a future, current, or previously administered licensing examination;

18.16 (ii) conduct which violates the standard of test administration, such as communicating
18.17 with another examinee during administration of the examination, copying another examinee's
18.18 answers, permitting another examinee to copy one's answers, or possessing unauthorized
18.19 materials; and

18.20 (iii) impersonating an examinee or permitting an impersonator to take the examination
18.21 on one's own behalf;

18.22 (3) conviction, during the previous five years, of a felony reasonably related to the
18.23 practice of physician assistant. Conviction as used in this subdivision includes a conviction
18.24 of an offense which if committed in this state would be deemed a felony without regard to
18.25 its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is
18.26 made or returned but the adjudication of guilt is either withheld or not entered;

18.27 (4) revocation, suspension, restriction, limitation, or other disciplinary action against
18.28 the person's physician assistant credentials in another state or jurisdiction, failure to report
18.29 to the board that charges regarding the person's credentials have been brought in another
18.30 state or jurisdiction, or having been refused licensure by any other state or jurisdiction;

19.1 (5) advertising which is false or misleading, violates any rule of the board, or claims
19.2 without substantiation the positive cure of any disease or professional superiority to or
19.3 greater skill than that possessed by another physician assistant;

19.4 (6) violating a rule adopted by the board or an order of the board, a state, or federal law
19.5 which relates to the practice of a physician assistant, or in part regulates the practice of a
19.6 physician assistant, including without limitation sections 604.201, 609.344, and 609.345,
19.7 or a state or federal narcotics or controlled substance law;

19.8 (7) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
19.9 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
19.10 a patient; or practice which is professionally incompetent, in that it may create unnecessary
19.11 danger to any patient's life, health, or safety, in any of which cases, proof of actual injury
19.12 need not be established;

19.13 ~~(8) failure to adhere to the provisions of the physician-physician assistant delegation~~
19.14 ~~agreement;~~

19.15 ~~(9)~~ (8) engaging in the practice of medicine beyond ~~that~~ what is allowed by the
19.16 ~~physician-physician assistant delegation agreement~~ under this chapter, or aiding or abetting
19.17 an unlicensed person in the practice of medicine;

19.18 ~~(10)~~ (9) adjudication as mentally incompetent, mentally ill or developmentally disabled,
19.19 or as a chemically dependent person, a person dangerous to the public, a sexually dangerous
19.20 person, or a person who has a sexual psychopathic personality by a court of competent
19.21 jurisdiction, within or without this state. Such adjudication shall automatically suspend a
19.22 license for its duration unless the board orders otherwise;

19.23 ~~(11)~~ (10) engaging in unprofessional conduct. Unprofessional conduct includes any
19.24 departure from or the failure to conform to the minimal standards of acceptable and prevailing
19.25 practice in which proceeding actual injury to a patient need not be established;

19.26 ~~(12)~~ (11) inability to practice with reasonable skill and safety to patients by reason of
19.27 illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material, or as
19.28 a result of any mental or physical condition, including deterioration through the aging
19.29 process or loss of motor skills;

19.30 ~~(13)~~ (12) revealing a privileged communication from or relating to a patient except when
19.31 otherwise required or permitted by law;

19.32 ~~(14)~~ (13) any identification of a physician assistant by the title "Physician," "Doctor,"
19.33 ~~or "Dr."~~ in a patient care setting or in a communication directed to the general public;

20.1 ~~(15)~~ (14) improper management of medical records, including failure to maintain adequate
20.2 medical records, to comply with a patient's request made pursuant to sections 144.291 to
20.3 144.298, or to furnish a medical record or report required by law;

20.4 ~~(16)~~ (15) engaging in abusive or fraudulent billing practices, including violations of the
20.5 federal Medicare and Medicaid laws or state medical assistance laws;

20.6 ~~(17)~~ (16) becoming addicted or habituated to a drug or intoxicant;

20.7 ~~(18)~~ (17) prescribing a drug or device for other than medically accepted therapeutic,
20.8 experimental, or investigative purposes authorized by a state or federal agency or referring
20.9 a patient to any health care provider as defined in sections 144.291 to 144.298 for services
20.10 or tests not medically indicated at the time of referral;

20.11 ~~(19)~~ (18) engaging in conduct with a patient which is sexual or may reasonably be
20.12 interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually
20.13 demeaning to a patient;

20.14 ~~(20)~~ (19) failure to make reports as required by section 147A.14 or to cooperate with an
20.15 investigation of the board as required by section 147A.15, subdivision 3;

20.16 ~~(21)~~ (20) knowingly providing false or misleading information that is directly related
20.17 to the care of that patient unless done for an accepted therapeutic purpose such as the
20.18 administration of a placebo;

20.19 ~~(22)~~ (21) aiding suicide or aiding attempted suicide in violation of section 609.215 as
20.20 established by any of the following:

20.21 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
20.22 of section 609.215, subdivision 1 or 2;

20.23 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
20.24 issued under section 609.215, subdivision 4;

20.25 (iii) a copy of the record of a judgment assessing damages under section 609.215,
20.26 subdivision 5; or

20.27 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
20.28 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
20.29 or 2; or

20.30 ~~(23)~~ (22) ~~failure to maintain annually reviewed and updated physician-physician assistant~~
20.31 ~~delegation agreements for each physician-physician assistant practice relationship, or failure~~
20.32 ~~to provide copies of such documents upon request by the board~~ failure to maintain the proof

21.1 of review document as required under section 147A.09, subdivision 3, or to provide a copy
 21.2 of the document upon request of the board.

21.3 Sec. 14. Minnesota Statutes 2018, section 147A.14, subdivision 4, is amended to read:

21.4 Subd. 4. **Licensed professionals.** Licensed health professionals and persons holding
 21.5 residency permits under section 147.0391, shall report to the board personal knowledge of
 21.6 any conduct which the person reasonably believes constitutes grounds for disciplinary action
 21.7 under this chapter by a physician assistant, including any conduct indicating that the person
 21.8 may be incompetent, or may have engaged in unprofessional conduct or may be medically
 21.9 or physically unable to engage safely in practice as a physician assistant. No report shall be
 21.10 required if the information was obtained in the course of a ~~physician-patient~~ provider-patient
 21.11 relationship if the patient is a physician assistant, and the treating ~~physician~~ provider
 21.12 successfully counsels the person to limit or withdraw from practice to the extent required
 21.13 by the impairment.

21.14 Sec. 15. Minnesota Statutes 2018, section 147A.16, is amended to read:

21.15 **147A.16 FORMS OF DISCIPLINARY ACTION.**

21.16 When the board finds that a licensed physician assistant has violated a provision of this
 21.17 chapter, it may do one or more of the following:

21.18 (1) revoke the license;

21.19 (2) suspend the license;

21.20 (3) impose limitations or conditions on the physician assistant's practice, including
 21.21 limiting the scope of practice to designated field specialties; ~~impose~~ imposing retraining or
 21.22 rehabilitation requirements; ~~require practice under additional supervision;~~ or ~~condition~~
 21.23 ~~continued~~ limiting practice ~~on~~ until demonstration of knowledge or skills by appropriate
 21.24 examination or other review of skill and competence;

21.25 (4) impose a civil penalty not exceeding \$10,000 for each separate violation, the amount
 21.26 of the civil penalty to be fixed so as to deprive the physician assistant of any economic
 21.27 advantage gained by reason of the violation charged or to reimburse the board for the cost
 21.28 of the investigation and proceeding; or

21.29 ~~(5) order the physician assistant to provide unremunerated professional service under~~
 21.30 ~~supervision at a designated public hospital, clinic, or other health care institution; or~~

21.31 ~~(6)~~ (5) censure or reprimand the licensed physician assistant.

22.1 Upon judicial review of any board disciplinary action taken under this chapter, the
22.2 reviewing court shall seal the administrative record, except for the board's final decision,
22.3 and shall not make the administrative record available to the public.

22.4 **Sec. 16. [147A.185] PRESCRIBING DRUGS AND THERAPEUTIC DEVICES.**

22.5 **Subd. 1. Diagnosis, prescribing, and ordering.** A physician assistant is authorized to:

22.6 (1) diagnose, prescribe, and institute therapy or referrals of patients to health care agencies
22.7 and providers;

22.8 (2) prescribe, procure, sign for, record, administer, and dispense over-the-counter drugs,
22.9 legend drugs, and controlled substances, including sample drugs; and

22.10 (3) plan and initiate a therapeutic regimen that includes ordering and prescribing durable
22.11 medical devices and equipment, nutrition, diagnostic services, and supportive services
22.12 including but not limited to home health care, hospice, physical therapy, and occupational
22.13 therapy.

22.14 **Subd. 2. Drug Enforcement Administration requirements.** (a) A physician assistant
22.15 must:

22.16 (1) comply with federal Drug Enforcement Administration (DEA) requirements related
22.17 to controlled substances; and

22.18 (2) file any and all of the physician assistant's DEA registrations and numbers with the
22.19 board.

22.20 (b) The board shall maintain current records of all physician assistants with DEA
22.21 registration and numbers.

22.22 **Subd. 3. Other requirements and restrictions.** (a) Each prescription initiated by a
22.23 physician assistant shall indicate the following:

22.24 (1) the date of issue;

22.25 (2) the name and address of the patient;

22.26 (3) the name and quantity of the drug prescribed;

22.27 (4) directions for use; and

22.28 (5) the name and address of the prescribing physician assistant.

23.1 (b) In prescribing, dispensing, and administering legend drugs, controlled substances,
 23.2 and medical devices, a physician assistant must comply with this chapter and chapters 151
 23.3 and 152.

23.4 Sec. 17. Minnesota Statutes 2018, section 147A.23, is amended to read:

23.5 **147A.23 RESPONDING TO DISASTER SITUATIONS.**

23.6 ~~(a) A physician assistant duly licensed or credentialed in a United States jurisdiction or~~
 23.7 ~~by a federal employer who is responding to a need for medical care created by an emergency~~
 23.8 ~~according to section 604A.01, or a state or local disaster may render such care as the~~
 23.9 ~~physician assistant is trained to provide, under the physician assistant's license or credential,~~
 23.10 ~~without the need of a physician-physician assistant delegation agreement or a notice of~~
 23.11 ~~intent to practice as required under section 147A.20. A physician assistant may provide~~
 23.12 ~~emergency care without physician supervision or under the supervision that is available.~~

23.13 ~~(b) The physician who provides supervision to a physician assistant while the physician~~
 23.14 ~~assistant is rendering care in accordance with this section may do so without meeting the~~
 23.15 ~~requirements of section 147A.20.~~

23.16 ~~(c) The supervising physician who otherwise provides supervision to a physician assistant~~
 23.17 ~~under a physician-physician assistant delegation agreement described in section 147A.20~~
 23.18 ~~shall not be held medically responsible for the care rendered by a physician assistant pursuant~~
 23.19 ~~to paragraph (a). Services provided by a physician assistant under paragraph (a) shall be~~
 23.20 ~~considered outside the scope of the relationship between the supervising physician and the~~
 23.21 ~~physician assistant.~~

23.22 Sec. 18. Minnesota Statutes 2019 Supplement, section 151.01, subdivision 23, is amended
 23.23 to read:

23.24 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
 23.25 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
 23.26 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, ~~or~~ licensed
 23.27 advanced practice registered nurse. ~~For purposes of sections 151.15, subdivision 4; 151.211,~~
 23.28 ~~subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (c), and (f);~~
 23.29 ~~and 151.461, "practitioner" also means a, or licensed physician assistant authorized to~~
 23.30 ~~prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15,~~
 23.31 ~~subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2,~~
 23.32 ~~paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense~~
 23.33 ~~and administer under chapter 150A. For purposes of sections 151.252, subdivision 3, and~~

24.1 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered
24.2 hormonal contraceptives, nicotine replacement medications, or opiate antagonists under
24.3 section 151.37, subdivision 14, 15, or 16.

24.4 Sec. 19. Minnesota Statutes 2019 Supplement, section 151.01, subdivision 27, is amended
24.5 to read:

24.6 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

24.7 (1) interpretation and evaluation of prescription drug orders;

24.8 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
24.9 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
24.10 and devices);

24.11 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
24.12 of safe and effective use of drugs, including the performance of laboratory tests that are
24.13 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
24.14 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory
24.15 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
24.16 agreement;

24.17 (4) participation in drug and therapeutic device selection; drug administration for first
24.18 dosage and medical emergencies; intramuscular and subcutaneous administration used for
24.19 the treatment of alcohol or opioid dependence; drug regimen reviews; and drug or
24.20 drug-related research;

24.21 (5) drug administration, through intramuscular and subcutaneous administration used
24.22 to treat mental illnesses as permitted under the following conditions:

24.23 (i) upon the order of a prescriber and the prescriber is notified after administration is
24.24 complete; or

24.25 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
24.26 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
24.27 modification, administration, and discontinuation of drug therapy is according to the protocol
24.28 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
24.29 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
24.30 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
24.31 or medication administration made pursuant to a protocol or collaborative practice agreement
24.32 must be documented by the pharmacist in the patient's medical record or reported by the
24.33 pharmacist to a practitioner responsible for the patient's care;

25.1 (6) participation in administration of influenza vaccines to all eligible individuals six
25.2 years of age and older and all other vaccines to patients 13 years of age and older by written
25.3 protocol with a physician licensed under chapter 147, a physician assistant authorized to
25.4 prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to
25.5 prescribe drugs under section 148.235, provided that:

25.6 (i) the protocol includes, at a minimum:

25.7 (A) the name, dose, and route of each vaccine that may be given;

25.8 (B) the patient population for whom the vaccine may be given;

25.9 (C) contraindications and precautions to the vaccine;

25.10 (D) the procedure for handling an adverse reaction;

25.11 (E) the name, signature, and address of the physician, physician assistant, or advanced
25.12 practice registered nurse;

25.13 (F) a telephone number at which the physician, physician assistant, or advanced practice
25.14 registered nurse can be contacted; and

25.15 (G) the date and time period for which the protocol is valid;

25.16 (ii) the pharmacist has successfully completed a program approved by the Accreditation
25.17 Council for Pharmacy Education specifically for the administration of immunizations or a
25.18 program approved by the board;

25.19 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
25.20 assess the immunization status of individuals prior to the administration of vaccines, except
25.21 when administering influenza vaccines to individuals age nine and older;

25.22 (iv) the pharmacist reports the administration of the immunization to the Minnesota
25.23 Immunization Information Connection; and

25.24 (v) the pharmacist complies with guidelines for vaccines and immunizations established
25.25 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
25.26 does not need to comply with those portions of the guidelines that establish immunization
25.27 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
25.28 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
25.29 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
25.30 drugs under section 148.235, provided that the order is consistent with the United States
25.31 Food and Drug Administration approved labeling of the vaccine;

26.1 (7) participation in the initiation, management, modification, and discontinuation of
26.2 drug therapy according to a written protocol or collaborative practice agreement between:
26.3 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
26.4 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
26.5 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
26.6 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
26.7 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement
26.8 must be documented by the pharmacist in the patient's medical record or reported by the
26.9 pharmacist to a practitioner responsible for the patient's care;

26.10 (8) participation in the storage of drugs and the maintenance of records;

26.11 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
26.12 devices;

26.13 (10) offering or performing those acts, services, operations, or transactions necessary
26.14 in the conduct, operation, management, and control of a pharmacy; ~~and~~

26.15 (11) participation in the initiation, management, modification, and discontinuation of
26.16 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

26.17 (i) a written protocol as allowed under clause (6); or

26.18 (ii) a written protocol with a community health board medical consultant or a practitioner
26.19 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
26.20 and

26.21 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
26.22 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
26.23 to section 151.37, subdivision 14, 15, or 16.

26.24 Sec. 20. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to
26.25 read:

26.26 Subd. 42. **Self-administered hormonal contraceptive.** "Self-administered hormonal
26.27 contraceptive" means a drug composed of a combination of hormones that is approved by
26.28 the United States Food and Drug Administration to prevent pregnancy and is administered
26.29 by the user.

27.1 Sec. 21. Minnesota Statutes 2018, section 151.37, subdivision 2, is amended to read:

27.2 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional
27.3 practice only, may prescribe, administer, and dispense a legend drug, and may cause the
27.4 same to be administered by a nurse, a physician assistant, or medical student or resident
27.5 under the practitioner's direction and supervision, and may cause a person who is an
27.6 appropriately certified, registered, or licensed health care professional to prescribe, dispense,
27.7 and administer the same within the expressed legal scope of the person's practice as defined
27.8 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
27.9 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
27.10 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
27.11 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
27.12 27, to adhere to a particular practice guideline or protocol when treating patients whose
27.13 condition falls within such guideline or protocol, and when such guideline or protocol
27.14 specifies the circumstances under which the legend drug is to be prescribed and administered.
27.15 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
27.16 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
27.17 This paragraph applies to a physician assistant only if the physician assistant meets the
27.18 requirements of section 147A.18.

27.19 (b) The commissioner of health, if a licensed practitioner, or a person designated by the
27.20 commissioner who is a licensed practitioner, may prescribe a legend drug to an individual
27.21 or by protocol for mass dispensing purposes where the commissioner finds that the conditions
27.22 triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The
27.23 commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe,
27.24 dispense, or administer a legend drug or other substance listed in subdivision 10 to control
27.25 tuberculosis and other communicable diseases. The commissioner may modify state drug
27.26 labeling requirements, and medical screening criteria and documentation, where time is
27.27 critical and limited labeling and screening are most likely to ensure legend drugs reach the
27.28 maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

27.29 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
27.30 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
27.31 practitioner's licensing board a statement indicating that the practitioner dispenses legend
27.32 drugs for profit, the general circumstances under which the practitioner dispenses for profit,
27.33 and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs
27.34 for profit after July 31, 1990, unless the statement has been filed with the appropriate
27.35 licensing board. For purposes of this paragraph, "profit" means (1) any amount received by

28.1 the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are
28.2 purchased in prepackaged form, or (2) any amount received by the practitioner in excess
28.3 of the acquisition cost of a legend drug plus the cost of making the drug available if the
28.4 legend drug requires compounding, packaging, or other treatment. The statement filed under
28.5 this paragraph is public data under section 13.03. This paragraph does not apply to a licensed
28.6 doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed
28.7 practitioner with the authority to prescribe, dispense, and administer a legend drug under
28.8 paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing
28.9 by a community health clinic when the profit from dispensing is used to meet operating
28.10 expenses.

28.11 (d) A prescription drug order for the following drugs is not valid, unless it can be
28.12 established that the prescription drug order was based on a documented patient evaluation,
28.13 including an examination, adequate to establish a diagnosis and identify underlying conditions
28.14 and contraindications to treatment:

28.15 (1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

28.16 (2) drugs defined by the Board of Pharmacy as controlled substances under section
28.17 152.02, subdivisions 7, 8, and 12;

28.18 (3) muscle relaxants;

28.19 (4) centrally acting analgesics with opioid activity;

28.20 (5) drugs containing butalbital; or

28.21 (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

28.22 For purposes of prescribing drugs listed in clause (6), the requirement for a documented
28.23 patient evaluation, including an examination, may be met through the use of telemedicine,
28.24 as defined in section 147.033, subdivision 1.

28.25 (e) For the purposes of paragraph (d), the requirement for an examination shall be met
28.26 if an in-person examination has been completed in any of the following circumstances:

28.27 (1) the prescribing practitioner examines the patient at the time the prescription or drug
28.28 order is issued;

28.29 (2) the prescribing practitioner has performed a prior examination of the patient;

28.30 (3) another prescribing practitioner practicing within the same group or clinic as the
28.31 prescribing practitioner has examined the patient;

29.1 (4) a consulting practitioner to whom the prescribing practitioner has referred the patient
29.2 has examined the patient; or

29.3 (5) the referring practitioner has performed an examination in the case of a consultant
29.4 practitioner issuing a prescription or drug order when providing services by means of
29.5 telemedicine.

29.6 (f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a
29.7 drug through the use of a guideline or protocol pursuant to paragraph (a).

29.8 (g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription
29.9 or dispensing a legend drug in accordance with the Expedited Partner Therapy in the
29.10 Management of Sexually Transmitted Diseases guidance document issued by the United
29.11 States Centers for Disease Control.

29.12 (h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of
29.13 legend drugs through a public health clinic or other distribution mechanism approved by
29.14 the commissioner of health or a community health board in order to prevent, mitigate, or
29.15 treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of
29.16 a biological, chemical, or radiological agent.

29.17 (i) No pharmacist employed by, under contract to, or working for a pharmacy located
29.18 within the state and licensed under section 151.19, subdivision 1, may dispense a legend
29.19 drug based on a prescription that the pharmacist knows, or would reasonably be expected
29.20 to know, is not valid under paragraph (d).

29.21 (j) No pharmacist employed by, under contract to, or working for a pharmacy located
29.22 outside the state and licensed under section 151.19, subdivision 1, may dispense a legend
29.23 drug to a resident of this state based on a prescription that the pharmacist knows, or would
29.24 reasonably be expected to know, is not valid under paragraph (d).

29.25 (k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner,
29.26 or, if not a licensed practitioner, a designee of the commissioner who is a licensed
29.27 practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of
29.28 a communicable disease according to the Centers For Disease Control and Prevention Partner
29.29 Services Guidelines.

29.30 Sec. 22. Minnesota Statutes 2018, section 151.37, is amended by adding a subdivision to
29.31 read:

29.32 Subd. 14. Self-administered hormonal contraceptives. (a) A pharmacist is authorized
29.33 to prescribe self-administered hormonal contraceptives if the intended use is contraception

30.1 in accordance with this subdivision. By January 1, 2021, the board shall develop a
30.2 standardized protocol for the pharmacist to follow in prescribing self-administrated hormonal
30.3 contraceptives. In developing the protocol, the board shall consult with the Minnesota Board
30.4 of Medical Practice; the Minnesota Board of Nursing; the commissioner of health; the
30.5 Minnesota section of the American Congress of Obstetricians and Gynecologists; professional
30.6 pharmacy associations; and professional associations of physicians, physician assistants,
30.7 and advanced practice registered nurses. The protocol must, at a minimum, include:

30.8 (1) requiring the patient to complete a self-screening tool to identify patient risk factors
30.9 for the use of self-administered hormonal contraceptives, based on the current United States
30.10 Medical Eligibility Criteria for Contraceptive Use developed by the federal Centers for
30.11 Disease Control and Prevention;

30.12 (2) requiring the pharmacist to review the screening tool with the patient;

30.13 (3) other assessments the pharmacist should make before prescribing self-administered
30.14 hormonal contraceptives;

30.15 (4) situations when the prescribing of self-administered hormonal contraceptives by a
30.16 pharmacist is contraindicated;

30.17 (5) situations when the pharmacist must refer a patient to the patient's primary care
30.18 provider or, if the patient does not have a primary care provider, to a nearby clinic or hospital;
30.19 and

30.20 (6) any additional information concerning the requirements and prohibitions in this
30.21 subdivision that the board considers necessary.

30.22 (b) Before a pharmacist is authorized to prescribe a self-administered hormonal
30.23 contraceptive to a patient under this subdivision, the pharmacist shall successfully complete
30.24 a training program on prescribing self-administered hormonal contraceptives that is offered
30.25 by a college of pharmacy or by a continuing education provider that is accredited by the
30.26 Accreditation Council for Pharmacy Education, or a program approved by the board. To
30.27 maintain authorization to prescribe, the pharmacist shall complete continuing education
30.28 requirements as specified by the board.

30.29 (c) Before prescribing a self-administered hormonal contraceptive, the pharmacist shall
30.30 follow the standardized protocol developed under paragraph (a), and if appropriate, may
30.31 prescribe a self-administered hormonal contraceptive to a patient, if the patient is:

30.32 (1) 18 years of age or older; or

31.1 (2) under the age of 18 if the patient has previously been prescribed a self-administered
31.2 hormonal contraceptive by a licensed physician, physician assistant, or advanced practice
31.3 registered nurse.

31.4 (d) The pharmacist shall provide counseling to the patient on the use of self-administered
31.5 hormonal contraceptives and provide the patient with a fact sheet that includes but is not
31.6 limited to the contraindications for use of the drug, the appropriate method for using the
31.7 drug, the need for medical follow-up, and any additional information listed in Minnesota
31.8 Rules, part 6800.0910, subpart 2, that is required to be given to a patient during the counseling
31.9 process. The pharmacist shall also provide the patient with a written record of the
31.10 self-administered hormonal contraceptive prescribed by the pharmacist.

31.11 (e) If a pharmacist prescribes and dispenses a self-administered hormonal contraceptive
31.12 under this subdivision, the pharmacist shall not prescribe a refill to the patient unless the
31.13 patient has evidence of a clinical visit with a physician, physician assistant, or advanced
31.14 practice registered nurse within the preceding three years.

31.15 (f) A pharmacist who is authorized to prescribe a self-administered hormonal
31.16 contraceptive is prohibited from delegating the prescribing to any other person. A pharmacist
31.17 intern registered pursuant to section 151.101 may prepare a prescription for a
31.18 self-administered hormonal contraceptive, but before the prescription is processed or
31.19 dispensed, a pharmacist authorized to prescribe under this subdivision must review, approve,
31.20 and sign the prescription.

31.21 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
31.22 management, modification, and discontinuation of drug therapy according to a protocol or
31.23 collaborative agreement as authorized in this section and in section 151.01, subdivision 27.

31.24 Sec. 23. Minnesota Statutes 2018, section 151.37, is amended by adding a subdivision to
31.25 read:

31.26 Subd. 15. **Nicotine replacement medications.** (a) A pharmacist is authorized to prescribe
31.27 nicotine replacement medications approved by the United States Food and Drug
31.28 Administration in accordance with this subdivision. By January 1, 2021, the board shall
31.29 develop a standardized protocol for the pharmacist to follow in prescribing nicotine
31.30 replacement medications. In developing the protocol, the board shall consult with the
31.31 Minnesota Board of Medical Practice; the Minnesota Board of Nursing; the commissioner
31.32 of health; professional pharmacy associations; and professional associations of physicians,
31.33 physician assistants, and advanced practice registered nurses.

32.1 (b) Before a pharmacist is authorized to prescribe nicotine replacement medications
32.2 under this subdivision, the pharmacist shall successfully complete a training program
32.3 specifically developed for prescribing nicotine replacement medications that is offered by
32.4 a college of pharmacy or by a continuing education provider that is accredited by the
32.5 Accreditation Council for Pharmacy Education, or a program approved by the board. To
32.6 maintain authorization to prescribe, the pharmacist shall complete continuing education
32.7 requirements as specified by the board.

32.8 (c) Before prescribing a nicotine replacement medication, the pharmacist shall follow
32.9 the appropriate standardized protocol developed under paragraph (a), and if appropriate,
32.10 may dispense to a patient a nicotine replacement medication.

32.11 (d) The pharmacist shall provide counseling to the patient on the use of the nicotine
32.12 replacement medication and provide the patient with a fact sheet that includes but is not
32.13 limited to the indications and contraindications for use of a nicotine replacement medication,
32.14 the appropriate method for using the medication or product, the need for medical follow-up,
32.15 and any additional information listed in Minnesota Rules, part 6800.0910, subpart 2, that
32.16 is required to be given to a patient during the counseling process. The pharmacist shall also
32.17 provide the patient with a written record of the medication prescribed by the pharmacist.

32.18 (e) A pharmacist who is authorized to prescribe a nicotine replacement medication under
32.19 this subdivision is prohibited from delegating the prescribing of the medication to any other
32.20 person. A pharmacist intern registered pursuant to section 151.101 may prepare a prescription
32.21 for the medication, but before the prescription is processed or dispensed, a pharmacist
32.22 authorized to prescribe under this subdivision must review, approve, and sign the prescription.

32.23 (f) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
32.24 management, modification, and discontinuation of drug therapy according to a protocol or
32.25 collaborative agreement as authorized in this section and in section 151.01, subdivision 27.

32.26 Sec. 24. Minnesota Statutes 2018, section 151.37, is amended by adding a subdivision to
32.27 read:

32.28 Subd. 16. **Opiate antagonists for the treatment of an acute opiate overdose.** (a) A
32.29 pharmacist is authorized to prescribe opiate antagonists for the treatment of an acute opiate
32.30 overdose. By January 1, 2021, the board shall develop a standardized protocol for the
32.31 pharmacist to follow in prescribing an opiate antagonist. In developing the protocol, the
32.32 board shall consult with the Minnesota Board of Medical Practice; the Minnesota Board of
32.33 Nursing; the commissioner of health; professional pharmacy associations; and professional
32.34 associations of physicians, physician assistants, and advanced practice registered nurses.

33.1 (b) Before a pharmacist is authorized to prescribe an opiate antagonist under this
33.2 subdivision, the pharmacist shall successfully complete a training program specifically
33.3 developed for prescribing opiate antagonists for the treatment of an acute opiate overdose
33.4 that is offered by a college of pharmacy or by a continuing education provider that is
33.5 accredited by the Accreditation Council for Pharmacy Education, or a program approved
33.6 by the board. To maintain authorization to prescribe, the pharmacist shall complete continuing
33.7 education requirements as specified by the board.

33.8 (c) Before prescribing an opiate antagonist under this subdivision, the pharmacist shall
33.9 follow the appropriate standardized protocol developed under paragraph (a), and if
33.10 appropriate, may dispense to a patient an opiate antagonist.

33.11 (d) The pharmacist shall provide counseling to the patient on the use of the opiate
33.12 antagonist and provide the patient with a fact sheet that includes but is not limited to the
33.13 indications and contraindications for use of the opiate antagonist, the appropriate method
33.14 for using the opiate antagonist, the need for medical follow-up, and any additional
33.15 information listed in Minnesota Rules, part 6800.0910, subpart 2, that is required to be given
33.16 to a patient during the counseling process. The pharmacist shall also provide the patient
33.17 with a written record of the opiate antagonist prescribed by the pharmacist.

33.18 (e) A pharmacist who prescribes an opiate antagonist under this subdivision is prohibited
33.19 from delegating the prescribing of the medication to any other person. A pharmacist intern
33.20 registered pursuant to section 151.101 may prepare the prescription for the opiate antagonist,
33.21 but before the prescription is processed or dispensed, a pharmacist authorized to prescribe
33.22 under this subdivision must review, approve, and sign the prescription.

33.23 (f) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
33.24 management, modification, and discontinuation of drug therapy according to a protocol as
33.25 authorized in this section and in section 151.01, subdivision 27.

33.26 Sec. 25. Minnesota Statutes 2019 Supplement, section 151.555, subdivision 3, is amended
33.27 to read:

33.28 Subd. 3. **Central repository requirements.** (a) The board ~~shall~~ may publish a request
33.29 for proposal for participants who meet the requirements of this subdivision and are interested
33.30 in acting as the central repository for the drug repository program. ~~The board~~ If the board
33.31 publishes a request for proposal, it shall follow all applicable state procurement procedures
33.32 in the selection process. The board may also work directly with the University of Minnesota
33.33 to establish a central repository.

34.1 (b) To be eligible to act as the central repository, the participant must be a wholesale
34.2 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance
34.3 with all applicable federal and state statutes, rules, and regulations.

34.4 (c) The central repository shall be subject to inspection by the board pursuant to section
34.5 151.06, subdivision 1.

34.6 (d) The central repository shall comply with all applicable federal and state laws, rules,
34.7 and regulations pertaining to the drug repository program, drug storage, and dispensing.
34.8 The facility must maintain in good standing any state license or registration that applies to
34.9 the facility.

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

34.11 Sec. 26. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

34.12 Subdivision 1. **Prescribing, dispensing, administering controlled substances in**
34.13 **Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine,
34.14 duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine,
34.15 a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed
34.16 physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and
34.17 in the course of professional practice only, may prescribe, administer, and dispense a
34.18 controlled substance included in Schedules II through V of section 152.02, may cause the
34.19 same to be administered by a nurse, an intern or an assistant under the direction and
34.20 supervision of the doctor, and may cause a person who is an appropriately certified and
34.21 licensed health care professional to prescribe and administer the same within the expressed
34.22 legal scope of the person's practice as defined in Minnesota Statutes.

34.23 Sec. 27. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is
34.24 amended to read:

34.25 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
34.26 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
34.27 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
34.28 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed
34.29 by or under contract with a community health board as defined in section 145A.02,
34.30 subdivision 5, for the purposes of communicable disease control.

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

35.1 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
35.2 ingredient" is defined as a substance that is represented for use in a drug and when used in
35.3 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
35.4 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
35.5 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
35.6 excipients which are included in the medical assistance formulary. Medical assistance covers
35.7 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
35.8 when the compounded combination is specifically approved by the commissioner or when
35.9 a commercially available product:

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

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

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

35.15 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
35.16 a licensed practitioner or by a licensed pharmacist who meets standards established by the
35.17 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
35.18 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
35.19 with documented vitamin deficiencies, vitamins for children under the age of seven and
35.20 pregnant or nursing women, and any other over-the-counter drug identified by the
35.21 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
35.22 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
35.23 disorders, and this determination shall not be subject to the requirements of chapter 14. A
35.24 pharmacist may prescribe over-the-counter medications as provided under this paragraph
35.25 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
35.26 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
35.27 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
35.28 and make referrals as needed to other health care professionals.

35.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
35.30 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
35.31 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
35.32 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
35.33 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
35.34 individuals, medical assistance may cover drugs from the drug classes listed in United States

36.1 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
36.2 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
36.3 not be covered.

36.4 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
36.5 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
36.6 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
36.7 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

36.8 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
36.9 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
36.10 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
36.11 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
36.12 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
36.13 pharmacist in accordance with section 151.37, subdivision 16.

36.14 Sec. 28. Minnesota Statutes 2018, section 256B.0625, subdivision 13h, is amended to
36.15 read:

36.16 Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers
36.17 medication therapy management services for a recipient taking prescriptions to treat or
36.18 prevent one or more chronic medical conditions. For purposes of this subdivision,
36.19 "medication therapy management" means the provision of the following pharmaceutical
36.20 care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's
36.21 medications:

36.22 (1) performing or obtaining necessary assessments of the patient's health status;

36.23 (2) formulating a medication treatment plan, which may include prescribing medications
36.24 or products in accordance with section 151.37, subdivision 14, 15, or 16;

36.25 (3) monitoring and evaluating the patient's response to therapy, including safety and
36.26 effectiveness;

36.27 (4) performing a comprehensive medication review to identify, resolve, and prevent
36.28 medication-related problems, including adverse drug events;

36.29 (5) documenting the care delivered and communicating essential information to the
36.30 patient's other primary care providers;

36.31 (6) providing verbal education and training designed to enhance patient understanding
36.32 and appropriate use of the patient's medications;

37.1 (7) providing information, support services, and resources designed to enhance patient
37.2 adherence with the patient's therapeutic regimens; and

37.3 (8) coordinating and integrating medication therapy management services within the
37.4 broader health care management services being provided to the patient.

37.5 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
37.6 the pharmacist as defined in section 151.01, subdivision 27.

37.7 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
37.8 must meet the following requirements:

37.9 (1) have a valid license issued by the Board of Pharmacy of the state in which the
37.10 medication therapy management service is being performed;

37.11 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
37.12 completed a structured and comprehensive education program approved by the Board of
37.13 Pharmacy and the American Council of Pharmaceutical Education for the provision and
37.14 documentation of pharmaceutical care management services that has both clinical and
37.15 didactic elements;

37.16 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
37.17 have developed a structured patient care process that is offered in a private or semiprivate
37.18 patient care area that is separate from the commercial business that also occurs in the setting,
37.19 or in home settings, including long-term care settings, group homes, and facilities providing
37.20 assisted living services, but excluding skilled nursing facilities; and

37.21 (4) make use of an electronic patient record system that meets state standards.

37.22 (c) For purposes of reimbursement for medication therapy management services, the
37.23 commissioner may enroll individual pharmacists as medical assistance providers. The
37.24 commissioner may also establish contact requirements between the pharmacist and recipient,
37.25 including limiting the number of reimbursable consultations per recipient.

37.26 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing
37.27 within a reasonable geographic distance of the patient, a pharmacist who meets the
37.28 requirements may provide the services via two-way interactive video. Reimbursement shall
37.29 be at the same rates and under the same conditions that would otherwise apply to the services
37.30 provided. To qualify for reimbursement under this paragraph, the pharmacist providing the
37.31 services must meet the requirements of paragraph (b), and must be located within an
37.32 ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient
37.33 must also be located within an ambulatory care setting that meets the requirements of

38.1 paragraph (b), clause (3). Services provided under this paragraph may not be transmitted
38.2 into the patient's residence.

38.3 (e) Medication therapy management services may be delivered into a patient's residence
38.4 via secure interactive video if the medication therapy management services are performed
38.5 electronically during a covered home care visit by an enrolled provider. Reimbursement
38.6 shall be at the same rates and under the same conditions that would otherwise apply to the
38.7 services provided. To qualify for reimbursement under this paragraph, the pharmacist
38.8 providing the services must meet the requirements of paragraph (b) and must be located
38.9 within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).

38.10 **Sec. 29. ISSUANCE OF PRESCRIPTIONS TO TREAT SUBSTANCE USE**
38.11 **DISORDERS.**

38.12 Subdivision 1. **Applicability during a peacetime emergency.** This section applies
38.13 during a peacetime emergency declared by the governor under Minnesota Statutes, section
38.14 12.31, subdivision 2, for an outbreak of COVID-19.

38.15 Subd. 2. **Use of telemedicine allowed.** For purposes of Minnesota Statutes, section
38.16 151.37, subdivision 2, paragraph (d), the requirement for an examination shall be met if the
38.17 prescribing practitioner has performed a telemedicine examination of the patient before
38.18 issuing a prescription drug order for the treatment of a substance use disorder.

38.19 Subd. 3. **Expiration.** This section expires 60 days after the peacetime emergency specified
38.20 in subdivision 1 is terminated or rescinded by proper authority.

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

38.22 **Sec. 30. REPEALER.**

38.23 Minnesota Statutes 2018, sections 147A.01, subdivisions 4, 11, 16a, 17a, 24, and 25;
38.24 147A.04; 147A.10; 147A.11; 147A.18, subdivisions 1, 2, and 3; and 147A.20, are repealed.

38.25 **EFFECTIVE DATE.** This section is effective July 1, 2020.

39.1 **ARTICLE 3**

39.2 **HEALTH CARE**

39.3 Section 1. Minnesota Statutes 2019 Supplement, section 16A.151, subdivision 2, is
39.4 amended to read:

39.5 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
39.6 injured persons or entities, this section does not prohibit distribution of money to the specific
39.7 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
39.8 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
39.9 to those persons or entities because they cannot readily be located or identified or because
39.10 the cost of distributing the money would outweigh the benefit to the persons or entities, the
39.11 money must be paid into the general fund.

39.12 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
39.13 may be deposited in that fund.

39.14 (c) This section does not prohibit a state official from distributing money to a person or
39.15 entity other than the state in litigation or potential litigation in which the state is a defendant
39.16 or potential defendant.

39.17 (d) State agencies may accept funds as directed by a federal court for any restitution or
39.18 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States
39.19 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue
39.20 account and are appropriated to the commissioner of the agency for the purpose as directed
39.21 by the federal court.

39.22 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph
39.23 (t), may be deposited as provided in section 16A.98, subdivision 12.

39.24 (f) Any money received by the state resulting from a settlement agreement or an assurance
39.25 of discontinuance entered into by the attorney general of the state, or a court order in litigation
39.26 brought by the attorney general of the state, on behalf of the state or a state agency, against
39.27 one or more opioid manufacturers or opioid wholesale drug distributors related to alleged
39.28 violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this
39.29 state or other alleged illegal actions that contributed to the excessive use of opioids, must
39.30 be deposited in a separate account in the state treasury and the commissioner shall notify
39.31 the chairs and ranking minority members of the Finance Committee in the senate and the
39.32 Ways and Means Committee in the house of representatives that an account has been created.
39.33 This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney
39.34 General's Office, to contract attorneys hired by the state or Attorney General's Office, or to

40.1 other state agency attorneys. If the licensing fees under section 151.065, subdivision 1,
40.2 clause (16), and subdivision 3, clause (14), are reduced and the registration fee under section
40.3 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, then
40.4 the commissioner shall transfer from the separate account created in this paragraph to the
40.5 opiate epidemic response ~~account~~ fund under section 256.043 an amount that ensures that
40.6 \$20,940,000 each fiscal year is available for distribution in accordance with section 256.043,
40.7 subdivisions 2 and 3.

40.8 Sec. 2. Minnesota Statutes 2018, section 62U.03, is amended to read:

40.9 **62U.03 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.**

40.10 (a) By January 1, 2010, health plan companies shall include health care homes in their
40.11 provider networks and by July 1, 2010, shall pay a care coordination fee for their members
40.12 who choose to enroll in health care homes certified by the ~~commissioners of health and~~
40.13 ~~human services~~ commissioner under section 256B.0751. Health plan companies shall develop
40.14 payment conditions and terms for the care coordination fee for health care homes participating
40.15 in their network in a manner that is consistent with the system developed under section
40.16 256B.0753. Nothing in this section shall restrict the ability of health plan companies to
40.17 selectively contract with health care providers, including health care homes. Health plan
40.18 companies may reduce or reallocate payments to other providers to ensure that
40.19 implementation of care coordination payments is cost neutral.

40.20 (b) By July 1, 2010, the commissioner of management and budget shall implement the
40.21 care coordination payments for participants in the state employee group insurance program.
40.22 The commissioner of management and budget may reallocate payments within the health
40.23 care system in order to ensure that the implementation of this section is cost neutral.

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

40.25 Sec. 3. Minnesota Statutes 2018, section 62U.04, subdivision 11, is amended to read:

40.26 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
40.27 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
40.28 designee shall only use the data submitted under subdivisions 4 and 5 for the following
40.29 purposes:

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

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

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

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

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

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

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

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

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

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

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

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

41.25 (d) The commissioner or the commissioner's designee may use the data submitted under
41.26 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
41.27 2023.

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

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

42.1 Sec. 4. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 6, is amended
42.2 to read:

42.3 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license
42.4 to lapse may reinstate the license with board approval and upon payment of any fees and
42.5 late fees in arrears, up to a maximum of \$1,000.

42.6 (b) A pharmacy technician who has allowed the technician's registration to lapse may
42.7 reinstate the registration with board approval and upon payment of any fees and late fees
42.8 in arrears, up to a maximum of \$90.

42.9 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics
42.10 provider, or a medical gas ~~distributor~~ dispenser who has allowed the license of the
42.11 establishment to lapse may reinstate the license with board approval and upon payment of
42.12 any fees and late fees in arrears.

42.13 (d) A controlled substance researcher who has allowed the researcher's registration to
42.14 lapse may reinstate the registration with board approval and upon payment of any fees and
42.15 late fees in arrears.

42.16 (e) A pharmacist owner of a professional corporation who has allowed the corporation's
42.17 registration to lapse may reinstate the registration with board approval and upon payment
42.18 of any fees and late fees in arrears.

42.19 Sec. 5. Minnesota Statutes 2019 Supplement, section 151.071, subdivision 2, is amended
42.20 to read:

42.21 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
42.22 grounds for disciplinary action:

42.23 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
42.24 registration contained in this chapter or the rules of the board. The burden of proof is on
42.25 the applicant to demonstrate such qualifications or satisfaction of such requirements;

42.26 (2) obtaining a license by fraud or by misleading the board in any way during the
42.27 application process or obtaining a license by cheating, or attempting to subvert the licensing
42.28 examination process. Conduct that subverts or attempts to subvert the licensing examination
42.29 process includes, but is not limited to: (i) conduct that violates the security of the examination
42.30 materials, such as removing examination materials from the examination room or having
42.31 unauthorized possession of any portion of a future, current, or previously administered
42.32 licensing examination; (ii) conduct that violates the standard of test administration, such as
42.33 communicating with another examinee during administration of the examination, copying

43.1 another examinee's answers, permitting another examinee to copy one's answers, or
43.2 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
43.3 impersonator to take the examination on one's own behalf;

43.4 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
43.5 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
43.6 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
43.7 in this subdivision includes a conviction of an offense that if committed in this state would
43.8 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
43.9 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
43.10 withheld or not entered thereon. The board may delay the issuance of a new license or
43.11 registration if the applicant has been charged with a felony until the matter has been
43.12 adjudicated;

43.13 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
43.14 or applicant is convicted of a felony reasonably related to the operation of the facility. The
43.15 board may delay the issuance of a new license or registration if the owner or applicant has
43.16 been charged with a felony until the matter has been adjudicated;

43.17 (5) for a controlled substance researcher, conviction of a felony reasonably related to
43.18 controlled substances or to the practice of the researcher's profession. The board may delay
43.19 the issuance of a registration if the applicant has been charged with a felony until the matter
43.20 has been adjudicated;

43.21 (6) disciplinary action taken by another state or by one of this state's health licensing
43.22 agencies:

43.23 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
43.24 license or registration in another state or jurisdiction, failure to report to the board that
43.25 charges or allegations regarding the person's license or registration have been brought in
43.26 another state or jurisdiction, or having been refused a license or registration by any other
43.27 state or jurisdiction. The board may delay the issuance of a new license or registration if an
43.28 investigation or disciplinary action is pending in another state or jurisdiction until the
43.29 investigation or action has been dismissed or otherwise resolved; and

43.30 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
43.31 license or registration issued by another of this state's health licensing agencies, failure to
43.32 report to the board that charges regarding the person's license or registration have been
43.33 brought by another of this state's health licensing agencies, or having been refused a license
43.34 or registration by another of this state's health licensing agencies. The board may delay the

44.1 issuance of a new license or registration if a disciplinary action is pending before another
44.2 of this state's health licensing agencies until the action has been dismissed or otherwise
44.3 resolved;

44.4 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
44.5 any order of the board, of any of the provisions of this chapter or any rules of the board or
44.6 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
44.7 pharmacy;

44.8 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
44.9 of the board, of any of the provisions of this chapter or the rules of the board or violation
44.10 of any federal, state, or local law relating to the operation of the facility;

44.11 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
44.12 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
44.13 a patient; or pharmacy practice that is professionally incompetent, in that it may create
44.14 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
44.15 actual injury need not be established;

44.16 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
44.17 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
44.18 technician or pharmacist intern if that person is performing duties allowed by this chapter
44.19 or the rules of the board;

44.20 (11) for an individual licensed or registered by the board, adjudication as mentally ill
44.21 or developmentally disabled, or as a chemically dependent person, a person dangerous to
44.22 the public, a sexually dangerous person, or a person who has a sexual psychopathic
44.23 personality, by a court of competent jurisdiction, within or without this state. Such
44.24 adjudication shall automatically suspend a license for the duration thereof unless the board
44.25 orders otherwise;

44.26 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
44.27 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
44.28 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
44.29 intern or performing duties specifically reserved for pharmacists under this chapter or the
44.30 rules of the board;

44.31 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
44.32 duty except as allowed by a variance approved by the board;

45.1 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
45.2 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
45.3 of material or as a result of any mental or physical condition, including deterioration through
45.4 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
45.5 pharmacist interns, or controlled substance researchers, the inability to carry out duties
45.6 allowed under this chapter or the rules of the board with reasonable skill and safety to
45.7 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
45.8 of material or as a result of any mental or physical condition, including deterioration through
45.9 the aging process or loss of motor skills;

45.10 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
45.11 ~~distributor~~ dispenser, or controlled substance researcher, revealing a privileged
45.12 communication from or relating to a patient except when otherwise required or permitted
45.13 by law;

45.14 (16) for a pharmacist or pharmacy, improper management of patient records, including
45.15 failure to maintain adequate patient records, to comply with a patient's request made pursuant
45.16 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

45.17 (17) fee splitting, including without limitation:

45.18 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
45.19 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

45.20 (ii) referring a patient to any health care provider as defined in sections 144.291 to
45.21 144.298 in which the licensee or registrant has a financial or economic interest as defined
45.22 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
45.23 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
45.24 and

45.25 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
45.26 does not have a significant ownership interest, fills a prescription drug order and the
45.27 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
45.28 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
45.29 benefit manager, or other person paying for the prescription or, in the case of veterinary
45.30 patients, the price for the filled prescription that is charged to the client or other person
45.31 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
45.32 an arrangement provided that the client or other person paying for the prescription is notified,
45.33 in writing and with each prescription dispensed, about the arrangement, unless such

46.1 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
46.2 production systems, in which case client notification would not be required;

46.3 (18) engaging in abusive or fraudulent billing practices, including violations of the
46.4 federal Medicare and Medicaid laws or state medical assistance laws or rules;

46.5 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
46.6 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
46.7 to a patient;

46.8 (20) failure to make reports as required by section 151.072 or to cooperate with an
46.9 investigation of the board as required by section 151.074;

46.10 (21) knowingly providing false or misleading information that is directly related to the
46.11 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
46.12 administration of a placebo;

46.13 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
46.14 established by any of the following:

46.15 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
46.16 of section 609.215, subdivision 1 or 2;

46.17 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
46.18 issued under section 609.215, subdivision 4;

46.19 (iii) a copy of the record of a judgment assessing damages under section 609.215,
46.20 subdivision 5; or

46.21 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
46.22 The board ~~shall~~ must investigate any complaint of a violation of section 609.215, subdivision
46.23 1 or 2;

46.24 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
46.25 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
46.26 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
46.27 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
46.28 of the facility under a lapsed or nonrenewed license or registration; and

46.29 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
46.30 from the health professionals services program for reasons other than the satisfactory
46.31 completion of the program.

47.1 Sec. 6. Minnesota Statutes 2018, section 151.071, subdivision 8, is amended to read:

47.2 Subd. 8. **Temporary suspension of license for pharmacies, drug wholesalers, drug**
47.3 **manufacturers, medical gas manufacturers, and medical gas ~~distributors~~ dispensers.** In
47.4 addition to any other remedy provided by law, the board may, without a hearing, temporarily
47.5 suspend the license or registration of a pharmacy, drug wholesaler, drug manufacturer,
47.6 medical gas manufacturer, or medical gas ~~distributor~~ dispenser if the board finds that the
47.7 licensee or registrant has violated a statute or rule that the board is empowered to enforce
47.8 and continued operation of the licensed facility would create a serious risk of harm to the
47.9 public. The suspension ~~shall~~ must take effect upon written notice to the licensee or registrant,
47.10 specifying the statute or rule violated. The suspension ~~shall~~ must remain in effect until the
47.11 board issues a final order in the matter after a hearing. At the time it issues the suspension
47.12 notice, the board ~~shall~~ must schedule a disciplinary hearing to be held pursuant to the
47.13 Administrative Procedure Act. The licensee or registrant ~~shall~~ must be provided with at
47.14 least 20 days' notice of any hearing held pursuant to this subdivision. The hearing ~~shall~~ must
47.15 be scheduled to begin no later than 30 days after the issuance of the suspension order.

47.16 Sec. 7. Minnesota Statutes 2019 Supplement, section 151.19, subdivision 3, is amended
47.17 to read:

47.18 Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not
47.19 licensed as a pharmacy or a practitioner ~~shall~~ must not engage in the retail sale or ~~distribution~~
47.20 dispensing of federally restricted medical gases without first obtaining a registration from
47.21 the board and paying the applicable fee specified in section 151.065. The registration ~~shall~~
47.22 must be displayed in a conspicuous place in the business for which it is issued and expires
47.23 on the date set by the board. It is unlawful for a person to sell or ~~distribute~~ dispense federally
47.24 restricted medical gases unless a certificate has been issued to that person by the board.

47.25 (b) Application for a medical gas ~~distributor~~ dispenser registration under this section
47.26 ~~shall~~ must be made in a manner specified by the board.

47.27 (c) ~~No~~ A registration ~~shall~~ must not be issued or renewed for a medical gas ~~distributor~~
47.28 dispenser located within the state unless the applicant agrees to operate in a manner prescribed
47.29 by federal and state law and according to the rules adopted by the board. ~~No~~ A license ~~shall~~
47.30 must not be issued for a medical gas ~~distributor~~ dispenser located outside of the state unless
47.31 the applicant agrees to operate in a manner prescribed by federal law and, when ~~distributing~~
47.32 dispensing medical gases for residents of this state, the laws of this state and Minnesota
47.33 Rules.

48.1 (d) ~~No~~ A registration shall must not be issued or renewed for a medical gas ~~distributor~~
48.2 dispenser that is required to be licensed or registered by the state in which it is physically
48.3 located unless the applicant supplies the board with proof of the licensure or registration.
48.4 The board may, by rule, establish standards for the registration of a medical gas ~~distributor~~
48.5 dispenser that is not required to be licensed or registered by the state in which it is physically
48.6 located.

48.7 (e) The board ~~shall~~ must require a separate registration for each medical gas ~~distributor~~
48.8 dispenser located within the state and for each facility located outside of the state from
48.9 which medical gases are ~~distributed~~ dispensed to residents of this state.

48.10 (f) Prior to the issuance of an initial or renewed registration for a medical gas ~~distributor~~
48.11 dispenser, the board may require the medical gas ~~distributor~~ dispenser to pass an inspection
48.12 conducted by an authorized representative of the board. In the case of a medical gas
48.13 ~~distributor~~ dispenser located outside of the state, the board may require the applicant to pay
48.14 the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant
48.15 furnishes the board with a report, issued by the appropriate regulatory agency of the state
48.16 in which the facility is located, of an inspection that has occurred within the 24 months
48.17 immediately preceding receipt of the license application by the board. The board may deny
48.18 licensure unless the applicant submits documentation satisfactory to the board that any
48.19 deficiencies noted in an inspection report have been corrected.

48.20 Sec. 8. Minnesota Statutes 2019 Supplement, section 151.252, subdivision 1, is amended
48.21 to read:

48.22 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
48.23 first obtaining a license from the board and paying any applicable fee specified in section
48.24 151.065.

48.25 (b) In addition to the license required under paragraph (a), each manufacturer required
48.26 to pay the registration fee under section 151.066 must pay the fee by June 1 of each year,
48.27 beginning June 1, 2020. In the event of a change of ownership of the manufacturer, the new
48.28 owner must pay the registration fee specified under section 151.066, subdivision 3, that the
48.29 original owner would have been assessed had the original owner retained ownership. The
48.30 registration fee collected under this paragraph shall be deposited in the opiate epidemic
48.31 response ~~account~~ fund established under section 256.043.

48.32 (c) Application for a drug manufacturer license under this section shall be made in a
48.33 manner specified by the board.

49.1 (d) No license shall be issued or renewed for a drug manufacturer unless the applicant
49.2 agrees to operate in a manner prescribed by federal and state law and according to Minnesota
49.3 Rules.

49.4 (e) No license shall be issued or renewed for a drug manufacturer that is required to be
49.5 registered pursuant to United States Code, title 21, section 360, unless the applicant supplies
49.6 the board with proof of registration. The board may establish by rule the standards for
49.7 licensure of drug manufacturers that are not required to be registered under United States
49.8 Code, title 21, section 360.

49.9 (f) No license shall be issued or renewed for a drug manufacturer that is required to be
49.10 licensed or registered by the state in which it is physically located unless the applicant
49.11 supplies the board with proof of licensure or registration. The board may establish, by rule,
49.12 standards for the licensure of a drug manufacturer that is not required to be licensed or
49.13 registered by the state in which it is physically located.

49.14 (g) The board shall require a separate license for each facility located within the state at
49.15 which drug manufacturing occurs and for each facility located outside of the state at which
49.16 drugs that are shipped into the state are manufactured, except a manufacturer of
49.17 opiate-containing controlled substances shall not be required to pay the fee under section
49.18 151.065, subdivision 1, clause (16), or subdivision 3, clause (14), for more than one facility.

49.19 (h) Prior to the issuance of an initial or renewed license for a drug manufacturing facility,
49.20 the board may require the facility to pass a current good manufacturing practices inspection
49.21 conducted by an authorized representative of the board. In the case of a drug manufacturing
49.22 facility located outside of the state, the board may require the applicant to pay the cost of
49.23 the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes
49.24 the board with a report, issued by the appropriate regulatory agency of the state in which
49.25 the facility is located or by the United States Food and Drug Administration, of an inspection
49.26 that has occurred within the 24 months immediately preceding receipt of the license
49.27 application by the board. The board may deny licensure unless the applicant submits
49.28 documentation satisfactory to the board that any deficiencies noted in an inspection report
49.29 have been corrected.

49.30 Sec. 9. Minnesota Statutes 2018, section 256.01, subdivision 29, is amended to read:

49.31 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
49.32 determinations of disability by the commissioner's state medical review team under sections
49.33 256B.055, ~~subdivision~~ subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9,
49.34 ~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted~~

50.1 ~~by county agencies with a referral~~ and seek additional information from providers, applicants,
50.2 and enrollees to support the determination of disability where necessary. Disability shall
50.3 be determined according to the rules of title XVI and title XIX of the Social Security Act
50.4 and pertinent rules and policies of the Social Security Administration.

50.5 (b) Prior to a denial or withdrawal of a requested determination of disability due to
50.6 insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary
50.7 and appropriate to a determination of disability, and (2) assist applicants and enrollees to
50.8 obtain the evidence, including, but not limited to, medical examinations and electronic
50.9 medical records.

50.10 (c) The commissioner shall provide the chairs of the legislative committees with
50.11 jurisdiction over health and human services finance and budget the following information
50.12 on the activities of the state medical review team by February 1 of each year:

50.13 (1) the number of applications to the state medical review team that were denied,
50.14 approved, or withdrawn;

50.15 (2) the average length of time from receipt of the application to a decision;

50.16 (3) the number of appeals, appeal results, and the length of time taken from the date the
50.17 person involved requested an appeal for a written decision to be made on each appeal;

50.18 (4) for applicants, their age, health coverage at the time of application, hospitalization
50.19 history within three months of application, and whether an application for Social Security
50.20 or Supplemental Security Income benefits is pending; and

50.21 (5) specific information on the medical certification, licensure, or other credentials of
50.22 the person or persons performing the medical review determinations and length of time in
50.23 that position.

50.24 (d) Any appeal made under section 256.045, subdivision 3, of a disability determination
50.25 made by the state medical review team must be decided according to the timelines under
50.26 section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within
50.27 the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be
50.28 immediately reviewed by the chief human services judge.

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

51.1 Sec. 10. Minnesota Statutes 2019 Supplement, section 256.042, subdivision 2, is amended
51.2 to read:

51.3 Subd. 2. **Membership.** (a) The council shall consist of the following 19 voting members,
51.4 appointed by the commissioner of human services except as otherwise specified, and three
51.5 nonvoting members:

51.6 (1) two members of the house of representatives, appointed in the following sequence:
51.7 the first from the majority party appointed by the speaker of the house and the second from
51.8 the minority party appointed by the minority leader. Of these two members, one member
51.9 must represent a district outside of the seven-county metropolitan area, and one member
51.10 must represent a district that includes the seven-county metropolitan area. The appointment
51.11 by the minority leader must ensure that this requirement for geographic diversity in
51.12 appointments is met;

51.13 (2) two members of the senate, appointed in the following sequence: the first from the
51.14 majority party appointed by the senate majority leader and the second from the minority
51.15 party appointed by the senate minority leader. Of these two members, one member must
51.16 represent a district outside of the seven-county metropolitan area and one member must
51.17 represent a district that includes the seven-county metropolitan area. The appointment by
51.18 the minority leader must ensure that this requirement for geographic diversity in appointments
51.19 is met;

51.20 (3) one member appointed by the Board of Pharmacy;

51.21 (4) one member who is a physician appointed by the Minnesota Medical Association;

51.22 (5) one member representing opioid treatment programs, sober living programs, or
51.23 substance use disorder programs licensed under chapter 245G;

51.24 (6) one member appointed by the Minnesota Society of Addiction Medicine who is an
51.25 addiction psychiatrist;

51.26 (7) one member representing professionals providing alternative pain management
51.27 therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

51.28 (8) one member representing nonprofit organizations conducting initiatives to address
51.29 the opioid epidemic, with the commissioner's initial appointment being a member
51.30 representing the Steve Rummler Hope Network, and subsequent appointments representing
51.31 this or other organizations;

52.1 (9) one member appointed by the Minnesota Ambulance Association who is serving
52.2 with an ambulance service as an emergency medical technician, advanced emergency
52.3 medical technician, or paramedic;

52.4 (10) one member representing the Minnesota courts who is a judge or law enforcement
52.5 officer;

52.6 (11) one public member who is a Minnesota resident and who is in opioid addiction
52.7 recovery;

52.8 (12) two members representing Indian tribes, one representing the Ojibwe tribes and
52.9 one representing the Dakota tribes;

52.10 (13) one public member who is a Minnesota resident and who is suffering from chronic
52.11 pain, intractable pain, or a rare disease or condition;

52.12 (14) one mental health advocate representing persons with mental illness;

52.13 (15) one member ~~representing~~ appointed by the Minnesota Hospital Association;

52.14 (16) one member representing a local health department; and

52.15 (17) the commissioners of human services, health, and corrections, or their designees,
52.16 who shall be ex officio nonvoting members of the council.

52.17 (b) The commissioner of human services shall coordinate the commissioner's
52.18 appointments to provide geographic, racial, and gender diversity, and shall ensure that at
52.19 least one-half of council members appointed by the commissioner reside outside of the
52.20 seven-county metropolitan area. Of the members appointed by the commissioner, to the
52.21 extent practicable, at least one member must represent a community of color
52.22 disproportionately affected by the opioid epidemic.

52.23 (c) The council is governed by section 15.059, except that members of the council shall
52.24 serve three-year terms and shall receive no compensation other than reimbursement for
52.25 expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

52.26 (d) The chair shall convene the council at least quarterly, and may convene other meetings
52.27 as necessary. The chair shall convene meetings at different locations in the state to provide
52.28 geographic access, and shall ensure that at least one-half of the meetings are held at locations
52.29 outside of the seven-county metropolitan area.

52.30 (e) The commissioner of human services shall provide staff and administrative services
52.31 for the advisory council.

52.32 (f) The council is subject to chapter 13D.

53.1 Sec. 11. Minnesota Statutes 2019 Supplement, section 256.042, subdivision 4, is amended
53.2 to read:

53.3 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the
53.4 grants proposed by the advisory council to be awarded for the upcoming fiscal year to the
53.5 chairs and ranking minority members of the legislative committees with jurisdiction over
53.6 health and human services policy and finance, by March 1 of each year, beginning March
53.7 1, 2020.

53.8 (b) The commissioner of human services shall award grants from the opiate epidemic
53.9 response ~~account~~ fund under section 256.043. The grants shall be awarded to proposals
53.10 selected by the advisory council that address the priorities in subdivision 1, paragraph (a),
53.11 clauses (1) to (4), unless otherwise appropriated by the legislature. No more than three
53.12 percent of the grant amount may be used by a grantee for administration.

53.13 Sec. 12. Minnesota Statutes 2019 Supplement, section 256.043, is amended to read:

53.14 **256.043 OPIATE EPIDEMIC RESPONSE ACCOUNT FUND.**

53.15 Subdivision 1. **Establishment.** The opiate epidemic response ~~account~~ fund is established
53.16 in the ~~special revenue fund~~ in the state treasury. The registration fees assessed by the Board
53.17 of Pharmacy under section 151.066 and the license fees identified in section 151.065,
53.18 subdivision 7, paragraphs (b) and (c), shall be deposited into the ~~account~~ fund. Beginning
53.19 in fiscal year 2021, for each fiscal year, the ~~funds in the account~~ fund shall be administered
53.20 according to this section.

53.21 ~~Subd. 2. **Transfers from account to state agencies.** (a) The commissioner shall transfer~~
53.22 ~~the following amounts to the agencies specified in this subdivision.~~

53.23 ~~(b) \$126,000 to the Board of Pharmacy for the collection of the registration fees under~~
53.24 ~~section 151.066.~~

53.25 ~~(c) \$672,000 to the commissioner of public safety for the Bureau of Criminal~~
53.26 ~~Apprehension. Of this amount, \$384,000 is for drug scientists and lab supplies and \$288,000~~
53.27 ~~is for special agent positions focused on drug interdiction and drug trafficking.~~

53.28 Subd. 3. **Appropriations from account fund.** (a) After the ~~transfers described in~~
53.29 ~~subdivision 2, and the appropriations in Laws 2019, chapter 63, article 3, section 1,~~
53.30 ~~paragraphs (e), (f), (g), and (h) are made, \$249,000 is appropriated to the commissioner of~~
53.31 ~~human services for the provision of administrative services to the Opiate Epidemic Response~~
53.32 ~~Advisory Council and for the administration of the grants awarded under paragraph (e) (e).~~

54.1 (b) \$126,000 is appropriated to the Board of Pharmacy for the collection of the registration
54.2 fees under section 151.066.

54.3 (c) \$672,000 is appropriated to the commissioner of public safety for the Bureau of
54.4 Criminal Apprehension. Of this amount, \$384,000 is for drug scientists and lab supplies
54.5 and \$288,000 is for special agent positions focused on drug interdiction and drug trafficking.

54.6 ~~(b)~~ (d) After the ~~transfers in subdivision 2 and the~~ appropriations in ~~paragraph~~ paragraphs
54.7 (a) to (c) are made, 50 percent of the remaining amount is appropriated to the commissioner
54.8 of human services for distribution to county social service and tribal social service agencies
54.9 to provide child protection services to children and families who are affected by addiction.
54.10 The commissioner shall distribute this money proportionally to counties and tribal social
54.11 service agencies based on out-of-home placement episodes where parental drug abuse is
54.12 the primary reason for the out-of-home placement using data from the previous calendar
54.13 year. County and tribal social service agencies receiving funds from the opiate epidemic
54.14 response ~~account~~ fund must annually report to the commissioner on how the funds were
54.15 used to provide child protection services, including measurable outcomes, as determined
54.16 by the commissioner. County social service agencies and tribal social service agencies must
54.17 not use funds received under this paragraph to supplant current state or local funding received
54.18 for child protection services for children and families who are affected by addiction.

54.19 ~~(e)~~ (e) After making the ~~transfers in subdivision 2 and the~~ appropriations in paragraphs
54.20 (a) ~~and (b)~~ to (d), the remaining ~~funds in the account are~~ amount in the fund is appropriated
54.21 to the commissioner to award grants as specified by the Opiate Epidemic Response Advisory
54.22 Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

54.23 Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of \$250,000,000 either
54.24 as a result of a settlement agreement or an assurance of discontinuance entered into by the
54.25 attorney general of the state, or resulting from a court order in litigation brought by the
54.26 attorney general of the state on behalf of the state or a state agency, against one or more
54.27 opioid manufacturers or opioid wholesale drug distributors related to alleged violations of
54.28 consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other
54.29 alleged illegal actions that contributed to the excessive use of opioids, or from the fees
54.30 collected under sections 151.065, subdivisions 1 and 3, and 151.066, that are deposited into
54.31 the opiate epidemic response ~~account~~ fund established in this section ~~256.043~~, or from a
54.32 combination of both, the fees specified in section 151.065, subdivisions 1, clause (16), and
54.33 3, clause (14), shall be reduced to \$5,260, and the opiate registration fee in section 151.066,
54.34 subdivision 3, shall be repealed.

55.1 (b) The commissioner of management and budget shall inform the board of pharmacy,
55.2 the governor, and the legislature when the amount specified in paragraph (a) has been
55.3 reached. The board shall apply the reduced license fee for the next licensure period.

55.4 (c) Notwithstanding paragraph (a), the reduction of the license fee in section 151.065,
55.5 subdivisions 1 and 3, and the repeal of the registration fee in section 151.066 shall not occur
55.6 before July 1, 2024.

55.7 Sec. 13. Minnesota Statutes 2018, section 256B.056, subdivision 1a, is amended to read:

55.8 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law
55.9 or rule or federal law or regulation, the methodologies used in counting income and assets
55.10 to determine eligibility for medical assistance for persons whose eligibility category is based
55.11 on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental
55.12 Security Income program shall be used, except as provided under subdivision 3, paragraph
55.13 (a), clause (6).

55.14 (2) Increases in benefits under title II of the Social Security Act shall not be counted as
55.15 income for purposes of this subdivision until July 1 of each year. Effective upon federal
55.16 approval, for children eligible under section 256B.055, subdivision 12, or for home and
55.17 community-based waiver services whose eligibility for medical assistance is determined
55.18 without regard to parental income, child support payments, including any payments made
55.19 by an obligor in satisfaction of or in addition to a temporary or permanent order for child
55.20 support, and Social Security payments are not counted as income.

55.21 (b)(1) The modified adjusted gross income methodology as defined in ~~the Affordable~~
55.22 ~~Care Act~~ United States Code, title 42, section 1396a(e)(14), shall be used for eligibility
55.23 categories based on:

55.24 (i) children under age 19 and their parents and relative caretakers as defined in section
55.25 256B.055, subdivision 3a;

55.26 (ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

55.27 (iii) pregnant women as defined in section 256B.055, subdivision 6;

55.28 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision
55.29 § 1; and

55.30 (v) adults without children as defined in section 256B.055, subdivision 15.

55.31 For these purposes, a "methodology" does not include an asset or income standard, or
55.32 accounting method, or method of determining effective dates.

56.1 (2) For individuals whose income eligibility is determined using the modified adjusted
56.2 gross income methodology in clause (1);

56.3 (i) the commissioner shall subtract from the individual's modified adjusted gross income
56.4 an amount equivalent to five percent of the federal poverty guidelines; and

56.5 (ii) the individual's current monthly income and household size is used to determine
56.6 eligibility for the 12-month eligibility period. If an individual's income is expected to vary
56.7 month to month, eligibility is determined based on the income predicted for the 12-month
56.8 eligibility period.

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

56.10 Sec. 14. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

56.11 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
56.12 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
56.13 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
56.14 Supplemental Security Income may have an income up to the Supplemental Security Income
56.15 standard in effect on that date.

56.16 (b) ~~Effective January 1, 2014,~~ To be eligible for medical assistance, under section
56.17 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
56.18 percent of the federal poverty guidelines for the household size.

56.19 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a
56.20 person may have an income up to 133 percent of federal poverty guidelines for the household
56.21 size.

56.22 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child
56.23 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for
56.24 the household size.

56.25 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
56.26 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
56.27 household size ~~or an equivalent standard when converted using modified adjusted gross~~
56.28 ~~income methodology as required under the Affordable Care Act. Children who are enrolled~~
56.29 ~~in medical assistance as of December 31, 2013, and are determined ineligible for medical~~
56.30 ~~assistance because of the elimination of income disregards under modified adjusted gross~~
56.31 ~~income methodology as defined in subdivision 1a remain eligible for medical assistance~~
56.32 ~~under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law~~

57.1 ~~111-3, until the date of their next regularly scheduled eligibility redetermination as required~~
57.2 ~~in subdivision 7a.~~

57.3 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
57.4 who are not residents of long-term care facilities, the commissioner shall disregard increases
57.5 in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons
57.6 eligible under paragraph (a), veteran aid and attendance benefits and Veterans Administration
57.7 unusual medical expense payments are considered income to the recipient.

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

57.9 Sec. 15. Minnesota Statutes 2018, section 256B.056, subdivision 7, is amended to read:

57.10 Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application
57.11 and for three months prior to application if the person was eligible in those prior months.
57.12 A redetermination of eligibility must occur every 12 months.

57.13 (b) For a person eligible for an insurance affordability program as defined in section
57.14 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
57.15 assistance, eligibility is available for the month the change was reported and for three months
57.16 prior to the month the change was reported, if the person was eligible in those prior months.

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

57.18 Sec. 16. Minnesota Statutes 2019 Supplement, section 256B.056, subdivision 7a, is
57.19 amended to read:

57.20 Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual
57.21 redetermination of eligibility based on information contained in the enrollee's case file and
57.22 other information available to the agency, including but not limited to information accessed
57.23 through an electronic database, without requiring the enrollee to submit any information
57.24 when sufficient data is available for the agency to renew eligibility.

57.25 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the
57.26 commissioner must provide the enrollee with a prepopulated renewal form containing
57.27 eligibility information available to the agency and permit the enrollee to submit the form
57.28 with any corrections or additional information to the agency and sign the renewal form via
57.29 any of the modes of submission specified in section 256B.04, subdivision 18.

57.30 (c) An enrollee who is terminated for failure to complete the renewal process may
57.31 subsequently submit the renewal form and required information within four months after
57.32 the date of termination and have coverage reinstated without a lapse, if otherwise eligible

58.1 under this chapter. The local agency may close the enrollee's case file if the required
58.2 information is not submitted within four months of termination.

58.3 (d) Notwithstanding paragraph (a), ~~individuals~~ a person who is eligible under subdivision
58.4 5 shall be ~~required to renew eligibility~~ subject to a review of the person's income every six
58.5 months.

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

58.7 Sec. 17. Minnesota Statutes 2018, section 256B.056, subdivision 10, is amended to read:

58.8 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are
58.9 applying for the continuation of medical assistance coverage following the end of the 60-day
58.10 postpartum period to update their income and asset information and to submit any required
58.11 income or asset verification.

58.12 (b) The commissioner shall determine the eligibility of private-sector health care coverage
58.13 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
58.14 256B.057, subdivision 1, paragraph ~~(b)~~ (c), and shall pay for private-sector coverage if this
58.15 is determined to be cost-effective.

58.16 (c) The commissioner shall verify assets and income for all applicants, and for all
58.17 recipients upon renewal.

58.18 (d) The commissioner shall utilize information obtained through the electronic service
58.19 established by the secretary of the United States Department of Health and Human Services
58.20 and other available electronic data sources in Code of Federal Regulations, title 42, sections
58.21 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
58.22 standards to define when information obtained electronically is reasonably compatible with
58.23 information provided by applicants and enrollees, including use of self-attestation, to
58.24 accomplish real-time eligibility determinations and maintain program integrity.

58.25 (e) Each person applying for or receiving medical assistance under section 256B.055,
58.26 subdivision 7, and any other person whose resources are required by law to be disclosed to
58.27 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
58.28 information from financial institutions to identify unreported accounts as required in section
58.29 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner
58.30 may determine that the applicant or recipient is ineligible for medical assistance. For purposes
58.31 of this paragraph, an authorization to identify unreported accounts meets the requirements
58.32 of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not
58.33 be furnished to the financial institution.

59.1 (f) County and tribal agencies shall comply with the standards established by the
59.2 commissioner for appropriate use of the asset verification system specified in section 256.01,
59.3 subdivision 18f.

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

59.5 Sec. 18. Minnesota Statutes 2018, section 256B.0561, subdivision 2, is amended to read:

59.6 Subd. 2. **Periodic data matching.** ~~(a) Beginning April 1, 2018,~~ The commissioner shall
59.7 conduct periodic data matching to identify recipients who, based on available electronic
59.8 data, may not meet eligibility criteria for the public health care program in which the recipient
59.9 is enrolled. The commissioner shall conduct data matching for medical assistance or
59.10 MinnesotaCare recipients at least once during a recipient's 12-month period of eligibility.

59.11 (b) If data matching indicates a recipient may no longer qualify for medical assistance
59.12 or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no
59.13 more than 30 days to confirm the information obtained through the periodic data matching
59.14 or provide a reasonable explanation for the discrepancy to the state or county agency directly
59.15 responsible for the recipient's case. If a recipient does not respond within the advance notice
59.16 period or does not respond with information that demonstrates eligibility or provides a
59.17 reasonable explanation for the discrepancy within the 30-day time period, the commissioner
59.18 shall terminate the recipient's eligibility in the manner provided for by the laws and
59.19 regulations governing the health care program for which the recipient has been identified
59.20 as being ineligible.

59.21 (c) The commissioner shall not terminate eligibility for a recipient who is cooperating
59.22 with the requirements of paragraph (b) and needs additional time to provide information in
59.23 response to the notification.

59.24 (d) A recipient whose eligibility was terminated according to paragraph (b) may be
59.25 eligible for medical assistance no earlier than the first day of the month in which the recipient
59.26 provides information that demonstrates the recipient's eligibility.

59.27 ~~(d)~~ (e) Any termination of eligibility for benefits under this section may be appealed as
59.28 provided for in sections 256.045 to 256.0451, and the laws governing the health care
59.29 programs for which eligibility is terminated.

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

60.1 Sec. 19. Minnesota Statutes 2018, section 256B.057, subdivision 1, is amended to read:

60.2 Subdivision 1. **Infants and pregnant women.** (a) An infant less than two years of age
60.3 ~~or a pregnant woman~~ is eligible for medical assistance if the ~~individual's~~ infant's countable
60.4 household income is equal to or less than ~~275~~ 283 percent of the federal poverty guideline
60.5 for the same household size ~~or an equivalent standard when converted using modified~~
60.6 ~~adjusted gross income methodology as required under the Affordable Care Act.~~ Medical
60.7 assistance for an uninsured infant younger than two years of age may be paid with federal
60.8 funds available under title XXI of the Social Security Act and the state children's health
60.9 insurance program, for an infant with countable income above 275 percent and equal to or
60.10 less than 283 percent of the federal poverty guideline for the household size.

60.11 (b) A pregnant woman is eligible for medical assistance if the woman's countable income
60.12 is equal to or less than 278 percent of the federal poverty guideline for the applicable
60.13 household size.

60.14 ~~(b)~~ (c) An infant born to a woman who was eligible for and receiving medical assistance
60.15 on the date of the child's birth shall continue to be eligible for medical assistance without
60.16 redetermination until the child's first birthday.

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

60.18 Sec. 20. Minnesota Statutes 2018, section 256B.057, subdivision 10, is amended to read:

60.19 Subd. 10. **Certain persons needing treatment for breast or cervical cancer.** (a)
60.20 Medical assistance may be paid for a person who:

60.21 (1) has been screened for breast or cervical cancer by ~~the Minnesota~~ any Centers for
60.22 Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection
60.23 Program (NBCCEDP)-funded breast and cervical cancer control program, and program
60.24 funds have been used to pay for the person's screening;

60.25 (2) according to the person's treating health professional, needs treatment, including
60.26 diagnostic services necessary to determine the extent and proper course of treatment, for
60.27 breast or cervical cancer, including precancerous conditions and early stage cancer;

60.28 (3) meets the income eligibility guidelines for ~~the Minnesota~~ any CDC NBCCEDP-funded
60.29 breast and cervical cancer control program;

60.30 (4) is under age 65;

60.31 (5) is not otherwise eligible for medical assistance under United States Code, title 42,
60.32 section 1396a(a)(10)(A)(i); and

61.1 (6) is not otherwise covered under creditable coverage, as defined under United States
61.2 Code, title 42, section 1396a(aa).

61.3 (b) Medical assistance provided for an eligible person under this subdivision shall be
61.4 limited to services provided during the period that the person receives treatment for breast
61.5 or cervical cancer.

61.6 (c) A person meeting the criteria in paragraph (a) is eligible for medical assistance
61.7 without meeting the eligibility criteria relating to income and assets in section 256B.056,
61.8 subdivisions 1a to 5a.

61.9 Sec. 21. Minnesota Statutes 2018, section 256B.0575, subdivision 1, is amended to read:

61.10 Subdivision 1. **Income deductions.** When an institutionalized person is determined
61.11 eligible for medical assistance, the income that exceeds the deductions in paragraphs (a)
61.12 and (b) must be applied to the cost of institutional care.

61.13 (a) The following amounts must be deducted from the institutionalized person's income
61.14 in the following order:

61.15 (1) the personal needs allowance under section 256B.35 or, for a veteran who does not
61.16 have a spouse or child, or a surviving spouse of a veteran having no child, the amount of
61.17 an improved pension received from the veteran's administration ~~not exceeding \$90 per~~
61.18 ~~month~~, whichever amount is greater;

61.19 (2) the personal allowance for disabled individuals under section 256B.36;

61.20 (3) if the institutionalized person has a legally appointed guardian or conservator, five
61.21 percent of the recipient's gross monthly income up to \$100 as reimbursement for guardianship
61.22 or conservatorship services;

61.23 (4) a monthly income allowance determined under section 256B.058, subdivision 2, but
61.24 only to the extent income of the institutionalized spouse is made available to the community
61.25 spouse;

61.26 (5) a monthly allowance for children under age 18 which, together with the net income
61.27 of the children, would provide income equal to the medical assistance standard for families
61.28 and children according to section 256B.056, subdivision 4, for a family size that includes
61.29 only the minor children. This deduction applies only if the children do not live with the
61.30 community spouse and only to the extent that the deduction is not included in the personal
61.31 needs allowance under section 256B.35, subdivision 1, as child support garnished under a
61.32 court order;

62.1 (6) a monthly family allowance for other family members, equal to one-third of the
62.2 difference between 122 percent of the federal poverty guidelines and the monthly income
62.3 for that family member;

62.4 (7) reparations payments made by the Federal Republic of Germany and reparations
62.5 payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

62.6 (8) all other exclusions from income for institutionalized persons as mandated by federal
62.7 law; and

62.8 (9) amounts for reasonable expenses, as specified in subdivision 2, incurred for necessary
62.9 medical or remedial care for the institutionalized person that are recognized under state law,
62.10 not medical assistance covered expenses, and not subject to payment by a third party.

62.11 For purposes of clause (6), "other family member" means a person who resides with the
62.12 community spouse and who is a minor or dependent child, dependent parent, or dependent
62.13 sibling of either spouse. "Dependent" means a person who could be claimed as a dependent
62.14 for federal income tax purposes under the Internal Revenue Code.

62.15 (b) Income shall be allocated to an institutionalized person for a period of up to three
62.16 calendar months, in an amount equal to the medical assistance standard for a family size of
62.17 one if:

62.18 (1) a physician or advanced practice registered nurse certifies that the person is expected
62.19 to reside in the long-term care facility for three calendar months or less;

62.20 (2) if the person has expenses of maintaining a residence in the community; and

62.21 (3) if one of the following circumstances apply:

62.22 (i) the person was not living together with a spouse or a family member as defined in
62.23 paragraph (a) when the person entered a long-term care facility; or

62.24 (ii) the person and the person's spouse become institutionalized on the same date, in
62.25 which case the allocation shall be applied to the income of one of the spouses.

62.26 For purposes of this paragraph, a person is determined to be residing in a licensed nursing
62.27 home, regional treatment center, or medical institution if the person is expected to remain
62.28 for a period of one full calendar month or more.

63.1 Sec. 22. Minnesota Statutes 2018, section 256B.0575, subdivision 2, is amended to read:

63.2 Subd. 2. **Reasonable expenses.** For the purposes of subdivision 1, paragraph (a), clause
63.3 (9), reasonable expenses are limited to expenses that have not been previously used as a
63.4 deduction from income and were not:

63.5 (1) for long-term care expenses incurred during a period of ineligibility as defined in
63.6 section 256B.0595, subdivision 2;

63.7 (2) incurred more than three months before the month of application associated with the
63.8 current period of eligibility;

63.9 (3) for expenses incurred by a recipient that are duplicative of services that are covered
63.10 under chapter 256B; ~~or~~

63.11 (4) nursing facility expenses incurred without a timely assessment as required under
63.12 section 256B.0911; or

63.13 (5) for private room fees incurred by an assisted living client as defined in section
63.14 144G.01, subdivision 3.

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

63.16 Sec. 23. Minnesota Statutes 2018, section 256B.0625, subdivision 1, is amended to read:

63.17 Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient
63.18 hospital services performed by hospitals holding Medicare certifications for the services
63.19 performed. ~~A second medical opinion is required prior to reimbursement for elective surgeries~~
63.20 ~~requiring a second opinion. The commissioner shall publish in the State Register a list of~~
63.21 ~~elective surgeries that require a second medical opinion prior to reimbursement, and the~~
63.22 ~~criteria and standards for deciding whether an elective surgery should require a second~~
63.23 ~~medical opinion. The list and the criteria and standards are not subject to the requirements~~
63.24 ~~of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion~~
63.25 ~~is required, made in accordance with rules governing that decision, is not subject to~~
63.26 ~~administrative appeal.~~

63.27 (b) When determining medical necessity for inpatient hospital services, the medical
63.28 review agent shall follow industry standard medical necessity criteria in determining the
63.29 following:

63.30 (1) whether a recipient's admission is medically necessary;

63.31 (2) whether the inpatient hospital services provided to the recipient were medically
63.32 necessary;

64.1 (3) whether the recipient's continued stay was or will be medically necessary; and

64.2 (4) whether all medically necessary inpatient hospital services were provided to the
64.3 recipient.

64.4 The medical review agent will determine medical necessity of inpatient hospital services,
64.5 including inpatient psychiatric treatment, based on a review of the patient's medical condition
64.6 and records, in conjunction with industry standard evidence-based criteria to ensure consistent
64.7 and optimal application of medical appropriateness criteria.

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

64.9 Sec. 24. Minnesota Statutes 2018, section 256B.0625, subdivision 27, is amended to read:

64.10 Subd. 27. **Organ and tissue transplants.** ~~All organ transplants must be performed at~~
64.11 ~~transplant centers meeting united network for organ sharing criteria or at Medicare-approved~~
64.12 ~~organ transplant centers.~~ Organ and tissue transplants are a covered service. Stem cell or
64.13 bone marrow transplant centers must meet the standards established by the Foundation for
64.14 the Accreditation of Hematopoietic Cell Therapy.

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

64.16 Sec. 25. Minnesota Statutes 2018, section 256B.0625, subdivision 64, is amended to read:

64.17 Subd. 64. **Investigational drugs, biological products, and devices, and clinical**
64.18 **trials.** ~~(a)~~ Medical assistance and the early periodic screening, diagnosis, and treatment
64.19 (EPSDT) program do not cover the costs of any services that are incidental to, associated
64.20 with, or resulting from the use of investigational drugs, biological products, or devices as
64.21 defined in section 151.375 or any other treatment that is part of an approved clinical trial
64.22 as defined in section 62Q.526. Participation of an enrollee in an approved clinical trial does
64.23 not preclude coverage of medically necessary services covered under this chapter that are
64.24 not related to the approved clinical trial.

64.25 ~~(b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program~~
64.26 ~~if all the following conditions are met:~~

64.27 ~~(1) the use of stiripentol is determined to be medically necessary;~~

64.28 ~~(2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether~~
64.29 ~~an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating~~
64.30 ~~partial epilepsy in infancy due to an SCN2A genetic mutation;~~

65.1 ~~(3) all other available covered prescription medications that are medically necessary for~~
65.2 ~~the enrollee have been tried without successful outcomes; and~~

65.3 ~~(4) the United States Food and Drug Administration has approved the treating physician's~~
65.4 ~~individual patient investigational new drug application (IND) for the use of stiripentol for~~
65.5 ~~treatment.~~

65.6 ~~This paragraph does not apply to MinnesotaCare coverage under chapter 256L.~~

65.7 Sec. 26. Minnesota Statutes 2018, section 256B.0751, is amended to read:

65.8 **256B.0751 HEALTH CARE HOMES.**

65.9 Subdivision 1. **Definitions.** (a) For purposes of ~~sections~~ section 256B.0751 ~~to 256B.0753,~~
65.10 the following definitions apply.

65.11 (b) "Commissioner" means the commissioner of ~~human services~~ health.

65.12 ~~(e) "Commissioners" means the commissioner of human services and the commissioner~~
65.13 ~~of health, acting jointly.~~

65.14 ~~(d)~~ (c) "Health plan company" has the meaning provided in section 62Q.01, subdivision
65.15 4.

65.16 ~~(e)~~ (d) "Personal clinician" means a physician licensed under chapter 147, a physician
65.17 assistant licensed and practicing under chapter 147A, or an advanced practice nurse licensed
65.18 and registered to practice under chapter 148.

65.19 ~~(f) "State health care program" means the medical assistance and MinnesotaCare~~
65.20 ~~programs.~~

65.21 Subd. 2. **Development and implementation of standards.** (a) ~~By July 1, 2009,~~ The
65.22 ~~commissioners~~ commissioner of health and ~~human services~~ shall develop and implement
65.23 standards of certification for health care homes ~~for state health care programs~~. In developing
65.24 these standards, the ~~commissioners~~ commissioner shall consider existing standards developed
65.25 by national independent accrediting and medical home organizations. The standards
65.26 developed by the ~~commissioners~~ commissioner must meet the following criteria:

65.27 (1) emphasize, enhance, and encourage the use of primary care, and include the use of
65.28 primary care physicians, advanced practice nurses, and physician assistants as personal
65.29 clinicians;

65.30 (2) focus on delivering high-quality, efficient, and effective health care services;

66.1 (3) encourage patient-centered care, including active participation by the patient and
66.2 family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate
66.3 in decision making and care plan development, and providing care that is appropriate to the
66.4 patient's race, ethnicity, and language;

66.5 (4) provide patients with a consistent, ongoing contact with a personal clinician or team
66.6 of clinical professionals to ensure continuous and appropriate care for the patient's condition;

66.7 (5) ensure that health care homes develop and maintain appropriate comprehensive care
66.8 plans for their patients with complex or chronic conditions, including an assessment of
66.9 health risks and chronic conditions;

66.10 (6) enable and encourage utilization of a range of qualified health care professionals,
66.11 including dedicated care coordinators, in a manner that enables providers to practice to the
66.12 fullest extent of their license;

66.13 (7) focus initially on patients who have or are at risk of developing chronic health
66.14 conditions;

66.15 (8) incorporate measures of quality, resource use, cost of care, and patient experience;

66.16 (9) ensure the use of health information technology and systematic follow-up, including
66.17 the use of patient registries; and

66.18 (10) encourage the use of scientifically based health care, patient decision-making aids
66.19 that provide patients with information about treatment options and their associated benefits,
66.20 risks, costs, and comparative outcomes, and other clinical decision support tools.

66.21 (b) In developing these standards, the ~~commissioners~~ commissioner shall consult with
66.22 national and local organizations working on health care home models, physicians, relevant
66.23 state agencies, health plan companies, hospitals, other providers, patients, and patient
66.24 advocates. ~~The commissioners may satisfy this requirement by continuing the provider~~
66.25 ~~directed care coordination advisory committee.~~

66.26 (c) For the purposes of developing and implementing these standards, the ~~commissioners~~
66.27 commissioner may use the expedited rulemaking process under section 14.389.

66.28 Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal
66.29 clinician or a primary care clinic may be certified as a health care home. If a primary care
66.30 clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health
66.31 care home. ~~In order~~ To be certified as a health care home, a clinician or clinic must meet
66.32 the standards set by the ~~commissioners~~ commissioner in accordance with this section.

67.1 Certification as a health care home is voluntary. ~~In order~~ To maintain their status as health
67.2 care homes, clinicians or clinics must renew their certification every three years.

67.3 (b) Clinicians or clinics certified as health care homes must offer their health care home
67.4 services to all their patients with complex or chronic health conditions who are interested
67.5 in participation.

67.6 (c) Health care homes must participate in the health care home collaborative established
67.7 under subdivision 5.

67.8 Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section
67.9 ~~shall preclude~~ precludes the continued development of existing medical or health care home
67.10 projects currently operating or under development by the commissioner of human services
67.11 or ~~preclude~~ precludes the commissioner of human services from establishing alternative
67.12 models and payment mechanisms for persons who are enrolled in integrated Medicare and
67.13 Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed
67.14 care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for
67.15 Medicare and medical assistance, are in the waiting period for Medicare, or who have other
67.16 primary coverage.

67.17 (b) The commissioner ~~of health~~ shall waive health care home certification requirements
67.18 if an applicant demonstrates that compliance with a certification requirement will create a
67.19 major financial hardship or is not feasible, and the applicant establishes an alternative way
67.20 to accomplish the objectives of the certification requirement.

67.21 Subd. 5. **Health care home collaborative.** ~~By July 1, 2009, The commissioners~~
67.22 commissioner shall establish a health care home collaborative to provide an opportunity for
67.23 health care homes and state agencies to exchange information related to quality improvement
67.24 and best practices.

67.25 Subd. 6. **Evaluation and continued development.** (a) For continued certification under
67.26 this section, health care homes must meet process, outcome, and quality standards as
67.27 developed and specified by the ~~commissioners~~ commissioner. The ~~commissioners~~
67.28 commissioner shall collect data from health care homes necessary for monitoring compliance
67.29 with certification standards and for evaluating the impact of health care homes on health
67.30 care quality, cost, and outcomes.

67.31 (b) The ~~commissioners~~ commissioner may contract with a private entity to perform an
67.32 evaluation of the effectiveness of health care homes. Data collected under this subdivision
67.33 is classified as nonpublic data under chapter 13.

68.1 Subd. 7. **Outreach.** ~~Beginning July 1, 2009,~~ The commissioner of human services shall
68.2 encourage state health care program enrollees who have a complex or chronic condition to
68.3 select a primary care clinic with clinicians who have been certified as health care homes.

68.4 Subd. 8. **Coordination with local services.** The health care home and the county shall
68.5 coordinate care and services provided to patients enrolled with a health care home who have
68.6 complex medical needs or a disability, and who need and are eligible for additional local
68.7 services administered by counties, including but not limited to waived services, mental
68.8 health services, social services, public health services, transportation, and housing. The
68.9 coordination of care and services must be as provided in the plan established by the patient
68.10 and the health care home.

68.11 Subd. 9. **Pediatric care coordination.** The commissioner of human services shall
68.12 implement a pediatric care coordination service for children with high-cost medical or
68.13 high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency
68.14 room use for acute, chronic, or psychiatric illness, who receive medical assistance services.
68.15 Care coordination services must be targeted to children not already receiving care
68.16 coordination through another service and may include but are not limited to the provision
68.17 of health care home services to children admitted to hospitals that do not currently provide
68.18 care coordination. Care coordination services must be provided by care coordinators who
68.19 are directly linked to provider teams in the care delivery setting, but who may be part of a
68.20 community care team shared by multiple primary care providers or practices. For purposes
68.21 of this subdivision, the commissioner of human services shall, to the extent possible, use
68.22 the existing health care home certification and payment structure established under this
68.23 section and section 256B.0753.

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

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

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

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

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

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

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

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

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

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

69.14 (d) The advisory committee shall have the ability to establish subcommittees on specific
69.15 topics. The advisory committee is governed by section 15.059. Notwithstanding section
69.16 15.059, the advisory committee does not expire.

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

69.18 Sec. 27. Minnesota Statutes 2018, section 256B.0753, subdivision 1, is amended to read:

69.19 Subdivision 1. **Development.** The commissioner of human services, in coordination
69.20 with the commissioner of health, shall develop a payment system that provides per-person
69.21 care coordination payments to health care homes certified under section 256B.0751 for
69.22 providing care coordination services and directly managing on-site or employing care
69.23 coordinators. The care coordination payments under this section are in addition to the quality
69.24 incentive payments in section 256B.0754, subdivision 1. The care coordination payment
69.25 system must vary the fees paid by thresholds of care complexity, with the highest fees being
69.26 paid for care provided to individuals requiring the most intensive care coordination. In
69.27 developing the criteria for care coordination payments, the commissioner shall consider the
69.28 feasibility of including the additional time and resources needed by patients with limited
69.29 English-language skills, cultural differences, or other barriers to health care. The
69.30 commissioner may determine a schedule for phasing in care coordination fees such that the
69.31 fees will be applied first to individuals who have, or are at risk of developing, complex or

70.1 chronic health conditions. ~~Development of the payment system must be completed by~~
70.2 ~~January 1, 2010.~~

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

70.4 Sec. 28. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision
70.5 to read:

70.6 Subd. 6e. **Dental services.** (a) If a dental provider is providing services to an enrollee
70.7 of a managed care plan or county-based purchasing plan based on a treatment plan that
70.8 requires more than one visit, the managed care plan or county-based purchasing plan or the
70.9 plan's subcontractor, if the plan subcontracts with a third party to administer dental services
70.10 to the plan's enrollees, must not require the completion of the treatment plan as a condition
70.11 of payment to the dental provider for services performed as part of the treatment plan. The
70.12 health plan or subcontractor must reimburse the dental provider for all services performed
70.13 by the provider regardless of whether the treatment plan is completed, as long as the enrollee
70.14 was covered under the plan at the time the service was performed.

70.15 (b) Nothing in paragraph (a) prevents a health plan or its subcontractor from paying for
70.16 services using a bundled payment method. If a bundled payment method is used and the
70.17 treatment plan covered by the payment is not completed for any reason, the health plan or
70.18 its subcontractor must reimburse the dental provider for the services performed, as long as
70.19 the enrollee was covered under the plan at the time the service was performed.

70.20 Sec. 29. Minnesota Statutes 2018, section 256B.75, is amended to read:

70.21 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

70.22 (a) For outpatient hospital facility fee payments for services rendered on or after October
70.23 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
70.24 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
70.25 which there is a federal maximum allowable payment. Effective for services rendered on
70.26 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
70.27 emergency room facility fees shall be increased by eight percent over the rates in effect on
70.28 December 31, 1999, except for those services for which there is a federal maximum allowable
70.29 payment. Services for which there is a federal maximum allowable payment shall be paid
70.30 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
70.31 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
70.32 upper limit. If it is determined that a provision of this section conflicts with existing or
70.33 future requirements of the United States government with respect to federal financial

71.1 participation in medical assistance, the federal requirements prevail. The commissioner
71.2 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
71.3 participation resulting from rates that are in excess of the Medicare upper limitations.

71.4 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
71.5 surgery hospital facility fee services for critical access hospitals designated under section
71.6 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
71.7 cost-finding methods and allowable costs of the Medicare program. Effective for services
71.8 provided on or after July 1, 2015, rates established for critical access hospitals under this
71.9 paragraph for the applicable payment year shall be the final payment and shall not be settled
71.10 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
71.11 year ending in ~~2016~~ 2017, the rate for outpatient hospital services shall be computed using
71.12 information from each hospital's Medicare cost report as filed with Medicare for the year
71.13 that is two years before the year that the rate is being computed. Rates shall be computed
71.14 using information from Worksheet C series until the department finalizes the medical
71.15 assistance cost reporting process for critical access hospitals. After the cost reporting process
71.16 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
71.17 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
71.18 related to rural health clinics and federally qualified health clinics, divided by ancillary
71.19 charges plus outpatient charges, excluding charges related to rural health clinics and federally
71.20 qualified health clinics.

71.21 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
71.22 Medicare outpatient prospective payment system shall be replaced by a budget neutral
71.23 prospective payment system that is derived using medical assistance data. The commissioner
71.24 shall provide a proposal to the 2003 legislature to define and implement this provision.

71.25 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
71.26 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
71.27 services is reduced by .5 percent from the current statutory rate.

71.28 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
71.29 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility
71.30 services before third-party liability and spenddown, is reduced five percent from the current
71.31 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
71.32 this paragraph.

71.33 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
71.34 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient

72.1 hospital facility services before third-party liability and spenddown, is reduced three percent
72.2 from the current statutory rates. Mental health services and facilities defined under section
72.3 256.969, subdivision 16, are excluded from this paragraph.

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

72.5 Sec. 30. Minnesota Statutes 2018, section 256L.03, subdivision 1, is amended to read:

72.6 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
72.7 services reimbursed under chapter 256B, with the exception of special education services,
72.8 home care nursing services, adult dental care services other than services covered under
72.9 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
72.10 services, personal care assistance and case management services, behavioral health home
72.11 services under section 256B.0757, and nursing home or intermediate care facilities services.

72.12 (b) No public funds shall be used for coverage of abortion under MinnesotaCare except
72.13 where the life of the female would be endangered or substantial and irreversible impairment
72.14 of a major bodily function would result if the fetus were carried to term; or where the
72.15 pregnancy is the result of rape or incest.

72.16 (c) Covered health services shall be expanded as provided in this section.

72.17 (d) For the purposes of covered health services under this section, "child" means an
72.18 individual younger than 19 years of age.

72.19 Sec. 31. Minnesota Statutes 2018, section 256L.15, subdivision 1, is amended to read:

72.20 Subdivision 1. **Premium determination for MinnesotaCare.** (a) Families with children
72.21 and individuals shall pay a premium determined according to subdivision 2.

72.22 (b) Members of the military and their families who meet the eligibility criteria for
72.23 MinnesotaCare upon eligibility approval made within 24 months following the end of the
72.24 member's tour of active duty shall have their premiums paid by the commissioner. The
72.25 effective date of coverage for an individual or family who meets the criteria of this paragraph
72.26 shall be the first day of the month following the month in which eligibility is approved. This
72.27 exemption applies for 12 months.

72.28 (c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their
72.29 families shall have their premiums waived by the commissioner in accordance with section
72.30 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An
72.31 individual must indicate status as an American Indian, as defined under Code of Federal
72.32 Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The

73.1 commissioner shall accept attestation of an individual's status as an American Indian as
 73.2 verification until the United States Department of Health and Human Services approves an
 73.3 electronic data source for this purpose.

73.4 ~~(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting~~
 73.5 ~~with the chairs and ranking minority members of the legislative committees with jurisdiction~~
 73.6 ~~over human services, shall increase premiums under subdivision 2 for recipients based on~~
 73.7 ~~June 2015 program enrollment. Premium increases shall be sufficient to increase projected~~
 73.8 ~~revenue to the fund described in section 16A.724 by at least \$27,800,000 for the biennium~~
 73.9 ~~ending June 30, 2017. The commissioner shall publish the revised premium scale on the~~
 73.10 ~~Department of Human Services website and in the State Register no later than June 15,~~
 73.11 ~~2015. The revised premium scale applies to all premiums on or after August 1, 2015, in~~
 73.12 ~~place of the scale under subdivision 2.~~

73.13 ~~(e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority~~
 73.14 ~~members of the legislative committees with jurisdiction over human services the revised~~
 73.15 ~~premium scale effective August 1, 2015, and statutory language to codify the revised~~
 73.16 ~~premium schedule.~~

73.17 ~~(f) Premium changes authorized under paragraph (d) must only apply to enrollees not~~
 73.18 ~~otherwise excluded from paying premiums under state or federal law. Premium changes~~
 73.19 ~~authorized under paragraph (d) must satisfy the requirements for premiums for the Basic~~
 73.20 ~~Health Program under title 42 of Code of Federal Regulations, section 600.505.~~

73.21 Sec. 32. Laws 2019, chapter 63, article 3, section 1, is amended to read:

73.22 Section 1. **APPROPRIATIONS.**

73.23 (a) **Board of Pharmacy; administration.** \$244,000 in fiscal year 2020 is appropriated
 73.24 from the general fund to the Board of Pharmacy for onetime information technology and
 73.25 operating costs for administration of licensing activities under Minnesota Statutes, section
 73.26 151.066. This is a onetime appropriation.

73.27 (b) **Commissioner of human services; administration.** \$309,000 in fiscal year 2020
 73.28 is appropriated from the general fund and \$60,000 in fiscal year 2021 is appropriated from
 73.29 the opiate epidemic response ~~account~~ fund to the commissioner of human services for the
 73.30 provision of administrative services to the Opiate Epidemic Response Advisory Council
 73.31 and for the administration of the grants awarded under paragraphs (f), (g), and (h). The
 73.32 opiate epidemic response ~~account~~ fund base for this appropriation is \$60,000 in fiscal year
 73.33 2022, \$60,000 in fiscal year 2023, \$60,000 in fiscal year 2024, and \$0 in fiscal year 2025.

74.1 (c) **Board of Pharmacy; administration.** \$126,000 in fiscal year 2020 is appropriated
74.2 from the general fund to the Board of Pharmacy for the collection of the registration fees
74.3 under section 151.066.

74.4 (d) **Commissioner of public safety; enforcement activities.** \$672,000 in fiscal year
74.5 2020 is appropriated from the general fund to the commissioner of public safety for the
74.6 Bureau of Criminal Apprehension. Of this amount, \$384,000 is for drug scientists and lab
74.7 supplies and \$288,000 is for special agent positions focused on drug interdiction and drug
74.8 trafficking.

74.9 (e) **Commissioner of management and budget; evaluation activities.** \$300,000 in
74.10 fiscal year 2020 is appropriated from the general fund and \$300,000 in fiscal year 2021 is
74.11 appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of
74.12 management and budget for evaluation activities under Minnesota Statutes, section 256.042,
74.13 subdivision 1, paragraph (c). The opiate epidemic response ~~account~~ fund base for this
74.14 appropriation is \$300,000 in fiscal year 2022, \$300,000 in fiscal year 2023, \$300,000 in
74.15 fiscal year 2024, and \$0 in fiscal year 2025.

74.16 (f) **Commissioner of human services; grants for Project ECHO.** \$400,000 in fiscal
74.17 year 2020 is appropriated from the general fund and \$400,000 in fiscal year 2021 is
74.18 appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of human
74.19 services for grants of \$200,000 to CHI St. Gabriel's Health Family Medical Center for the
74.20 opioid-focused Project ECHO program and \$200,000 to Hennepin Health Care for the
74.21 opioid-focused Project ECHO program. The opiate epidemic response ~~account~~ fund base
74.22 for this appropriation is \$400,000 in fiscal year 2022, \$400,000 in fiscal year 2023, \$400,000
74.23 in fiscal year 2024, and \$0 in fiscal year 2025.

74.24 (g) **Commissioner of human services; opioid overdose prevention grant.** \$100,000
74.25 in fiscal year 2020 is appropriated from the general fund and \$100,000 in fiscal year 2021
74.26 is appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of
74.27 human services for a grant to a nonprofit organization that has provided overdose prevention
74.28 programs to the public in at least 60 counties within the state, for at least three years, has
74.29 received federal funding before January 1, 2019, and is dedicated to addressing the opioid
74.30 epidemic. The grant must be used for opioid overdose prevention, community asset mapping,
74.31 education, and overdose antagonist distribution. The opiate epidemic response ~~account~~ fund
74.32 base for this appropriation is \$100,000 in fiscal year 2022, \$100,000 in fiscal year 2023,
74.33 \$100,000 in fiscal year 2024, and \$0 in fiscal year 2025.

75.1 (h) **Commissioner of human services; traditional healing.** \$2,000,000 in fiscal year
75.2 2020 is appropriated from the general fund and \$2,000,000 in fiscal year 2021 is appropriated
75.3 from the opiate epidemic response ~~account~~ fund to the commissioner of human services to
75.4 award grants to tribal nations and five urban Indian communities for traditional healing
75.5 practices to American Indians and to increase the capacity of culturally specific providers
75.6 in the behavioral health workforce. The opiate epidemic response ~~account~~ fund base for
75.7 this appropriation is \$2,000,000 in fiscal year 2022, \$2,000,000 in fiscal year 2023,
75.8 \$2,000,000 in fiscal year 2024, and \$0 in fiscal year 2025.

75.9 (i) **Board of Dentistry; continuing education.** \$11,000 in fiscal year 2020 is
75.10 appropriated from the state government special revenue fund to the Board of Dentistry to
75.11 implement the continuing education requirements under Minnesota Statutes, section 214.12,
75.12 subdivision 6.

75.13 (j) **Board of Medical Practice; continuing education.** \$17,000 in fiscal year 2020 is
75.14 appropriated from the state government special revenue fund to the Board of Medical Practice
75.15 to implement the continuing education requirements under Minnesota Statutes, section
75.16 214.12, subdivision 6.

75.17 (k) **Board of Nursing; continuing education.** \$17,000 in fiscal year 2020 is appropriated
75.18 from the state government special revenue fund to the Board of Nursing to implement the
75.19 continuing education requirements under Minnesota Statutes, section 214.12, subdivision
75.20 6.

75.21 (l) **Board of Optometry; continuing education.** \$5,000 in fiscal year 2020 is
75.22 appropriated from the state government special revenue fund to the Board of Optometry to
75.23 implement the continuing education requirements under Minnesota Statutes, section 214.12,
75.24 subdivision 6.

75.25 (m) **Board of Podiatric Medicine; continuing education.** \$5,000 in fiscal year 2020
75.26 is appropriated from the state government special revenue fund to the Board of Podiatric
75.27 Medicine to implement the continuing education requirements under Minnesota Statutes,
75.28 section 214.12, subdivision 6.

75.29 (n) **Commissioner of health; nonnarcotic pain management and wellness.** \$1,250,000
75.30 is appropriated in fiscal year 2020 from the general fund to the commissioner of health, to
75.31 provide funding for:

75.32 (1) statewide mapping and assessment of community-based nonnarcotic pain management
75.33 and wellness resources; and

76.1 (2) up to five demonstration projects in different geographic areas of the state to provide
76.2 community-based nonnarcotic pain management and wellness resources to patients and
76.3 consumers.

76.4 The demonstration projects must include an evaluation component and scalability analysis.
76.5 The commissioner shall award the grant for the statewide mapping and assessment, and the
76.6 demonstration project grants, through a competitive request for proposal process. Grants
76.7 for statewide mapping and assessment and demonstration projects may be awarded
76.8 simultaneously. In awarding demonstration project grants, the commissioner shall give
76.9 preference to proposals that incorporate innovative community partnerships, are informed
76.10 and led by people in the community where the project is taking place, and are culturally
76.11 relevant and delivered by culturally competent providers. This is a onetime appropriation.

76.12 (o) **Commissioner of health; administration.** \$38,000 in fiscal year 2020 is appropriated
76.13 from the general fund to the commissioner of health for the administration of the grants
76.14 awarded in paragraph (n).

76.15 Sec. 33. Laws 2019, chapter 63, article 3, section 2, is amended to read:

76.16 Sec. 2. **TRANSFER.**

76.17 By June 30, 2021, the commissioner of human services shall transfer \$5,439,000 from
76.18 the opiate epidemic response ~~account~~ fund to the general fund. This is a onetime transfer.

76.19 Sec. 34. Laws 2020, chapter 71, article 2, section 5, is amended to read:

76.20 Sec. 5. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 1, is amended
76.21 to read:

76.22 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
76.23 follows:

76.24 (1) pharmacist licensed by examination, \$175;

76.25 (2) pharmacist licensed by reciprocity, \$275;

76.26 (3) pharmacy intern, \$50;

76.27 (4) pharmacy technician, \$50;

76.28 (5) pharmacy, \$260;

76.29 (6) drug wholesaler, legend drugs only, \$5,260;

- 77.1 (7) drug wholesaler, legend and nonlegend drugs, \$5,260;
- 77.2 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;
- 77.3 (9) drug wholesaler, medical gases, \$5,260 for the first facility and \$260 for each
77.4 additional facility;
- 77.5 (10) third-party logistics provider, \$260;
- 77.6 (11) drug manufacturer, nonopiate legend drugs only, \$5,260;
- 77.7 (12) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;
- 77.8 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$5,260;
- 77.9 (14) drug manufacturer, medical gases, \$5,260 for the first facility and \$260 for each
77.10 additional facility;
- 77.11 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;
- 77.12 (16) drug manufacturer of opiate-containing controlled substances listed in section
77.13 152.02, subdivisions 3 to 5, ~~\$55,000~~ \$55,260;
- 77.14 (17) medical gas ~~distributor~~ dispenser, \$260;
- 77.15 (18) controlled substance researcher, \$75; and
- 77.16 (19) pharmacy professional corporation, \$150.

77.17 **EFFECTIVE DATE.** This section is effective July 1, 2020, and applies to any license
77.18 issued on or after that date.

77.19 Sec. 35. Laws 2020, chapter 71, article 2, section 6, is amended to read:

77.20 Sec. 6. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 3, is amended
77.21 to read:

77.22 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
77.23 follows:

- 77.24 (1) pharmacist, \$175;
- 77.25 (2) pharmacy technician, \$50;
- 77.26 (3) pharmacy, \$260;
- 77.27 (4) drug wholesaler, legend drugs only, \$5,260;
- 77.28 (5) drug wholesaler, legend and nonlegend drugs, \$5,260;

- 78.1 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;
- 78.2 (7) drug wholesaler, medical gases, \$5,260 for the first facility and \$260 for each
78.3 additional facility;
- 78.4 (8) third-party logistics provider, \$260;
- 78.5 (9) drug manufacturer, nonopiate legend drugs only, \$5,260;
- 78.6 (10) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;
- 78.7 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$5,260;
- 78.8 (12) drug manufacturer, medical gases, \$5,260 for the first facility and \$260 for each
78.9 additional facility;
- 78.10 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;
- 78.11 (14) drug manufacturer of opiate-containing controlled substances listed in section
78.12 152.02, subdivisions 3 to 5, ~~\$55,000~~ \$55,260;
- 78.13 (15) medical gas ~~distributor~~ dispenser, \$260;
- 78.14 (16) controlled substance researcher, \$75; and
- 78.15 (17) pharmacy professional corporation, \$100.

78.16 **EFFECTIVE DATE.** This section is effective July 1, 2020, and applies to any license
78.17 renewed on or after that date.

78.18 Sec. 36. Laws 2020, chapter 71, article 2, section 7, is amended to read:

78.19 Sec. 7. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 7, is amended
78.20 to read:

78.21 Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the
78.22 exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state
78.23 government special revenue fund.

78.24 (b) \$5,000 of each fee collected under subdivision 1, clauses (6) to (9), and (11) to (15),
78.25 and subdivision 3, clauses (4) to (7), and (9) to (13), and ~~the fees~~ \$55,000 of each fee
78.26 collected under subdivision 1, clause (16), and subdivision 3, clause (14), shall be deposited
78.27 in the opiate epidemic response ~~account~~ fund established in section 256.043.

79.1 (c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14),
 79.2 are reduced under section 256.043, \$5,000 of the reduced fee shall be deposited in the opiate
 79.3 epidemic response ~~account~~ fund in section 256.043.

79.4 Sec. 37. **REVISOR INSTRUCTION.**

79.5 (a) The revisor of statutes shall renumber the provisions of Minnesota Statutes listed in
 79.6 column A to the references listed in column B.

79.7	<u>Column A</u>	<u>Column B</u>
79.8	<u>256B.0751, subdivision 1</u>	<u>62U.03, subdivision 2</u>
79.9	<u>256B.0751, subdivision 2</u>	<u>62U.03, subdivision 3</u>
79.10	<u>256B.0751, subdivision 3</u>	<u>62U.03, subdivision 4</u>
79.11	<u>256B.0751, subdivision 4</u>	<u>62U.03, subdivision 5</u>
79.12	<u>256B.0751, subdivision 5</u>	<u>62U.03, subdivision 6</u>
79.13	<u>256B.0751, subdivision 6</u>	<u>62U.03, subdivision 7</u>
79.14	<u>256B.0751, subdivision 7</u>	<u>62U.03, subdivision 8</u>
79.15	<u>256B.0751, subdivision 8</u>	<u>62U.03, subdivision 9</u>
79.16	<u>256B.0751, subdivision 9</u>	<u>62U.03, subdivision 10</u>
79.17	<u>256B.0751, subdivision 10</u>	<u>62U.03, subdivision 11</u>

79.18 (b) The revisor of statutes shall change the applicable references to Minnesota Statutes,
 79.19 section 256B.0751, to section 62U.03. The revisor shall make necessary cross-reference
 79.20 changes in Minnesota Statutes consistent with the renumbering. The revisor shall also make
 79.21 technical and other necessary changes to sentence structure to preserve the meaning of the
 79.22 text.

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

79.24 Sec. 38. **REPEALER.**

79.25 Minnesota Statutes 2018, sections 62U.15, subdivision 2; 256B.057, subdivision 8;
 79.26 256B.0752; and 256L.04, subdivision 13, are repealed.

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

80.1

ARTICLE 4

80.2

ADVANCED PRACTICE REGISTERED NURSES

80.3 Section 1. Minnesota Statutes 2018, section 62D.09, subdivision 1, is amended to read:

80.4 Subdivision 1. **Marketing requirements.** (a) Any written marketing materials which
80.5 may be directed toward potential enrollees and which include a detailed description of
80.6 benefits provided by the health maintenance organization shall include a statement of enrollee
80.7 information and rights as described in section 62D.07, subdivision 3, clauses (2) and (3).
80.8 Prior to any oral marketing presentation, the agent marketing the plan must inform the
80.9 potential enrollees that any complaints concerning the material presented should be directed
80.10 to the health maintenance organization, the commissioner of health, or, if applicable, the
80.11 employer.

80.12 (b) Detailed marketing materials must affirmatively disclose all exclusions and limitations
80.13 in the organization's services or kinds of services offered to the contracting party, including
80.14 but not limited to the following types of exclusions and limitations:

80.15 (1) health care services not provided;

80.16 (2) health care services requiring co-payments or deductibles paid by enrollees;

80.17 (3) the fact that access to health care services does not guarantee access to a particular
80.18 provider type; and

80.19 (4) health care services that are or may be provided only by referral of a physician or
80.20 advanced practice registered nurse.

80.21 (c) No marketing materials may lead consumers to believe that all health care needs will
80.22 be covered. All marketing materials must alert consumers to possible uncovered expenses
80.23 with the following language in bold print: "THIS HEALTH CARE PLAN MAY NOT
80.24 COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT
80.25 CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED." Immediately
80.26 following the disclosure required under paragraph (b), clause (3), consumers must be given
80.27 a telephone number to use to contact the health maintenance organization for specific
80.28 information about access to provider types.

80.29 (d) The disclosures required in paragraphs (b) and (c) are not required on billboards or
80.30 image, and name identification advertisement.

81.1 Sec. 2. Minnesota Statutes 2018, section 62E.06, subdivision 1, is amended to read:

81.2 Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a
81.3 number three qualified plan if it otherwise meets the requirements established by chapters
81.4 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in
81.5 Minnesota, and meets or exceeds the following minimum standards:

81.6 (a) The minimum benefits for a covered individual shall, subject to the other provisions
81.7 of this subdivision, be equal to at least 80 percent of the cost of covered services in excess
81.8 of an annual deductible which does not exceed \$150 per person. The coverage shall include
81.9 a limitation of \$3,000 per person on total annual out-of-pocket expenses for services covered
81.10 under this subdivision. The coverage shall not be subject to a lifetime maximum on essential
81.11 health benefits.

81.12 The prohibition on lifetime maximums for essential health benefits and \$3,000 limitation
81.13 on total annual out-of-pocket expenses shall not be subject to change or substitution by use
81.14 of an actuarially equivalent benefit.

81.15 (b) Covered expenses shall be the usual and customary charges for the following services
81.16 and articles when prescribed by a physician or advanced practice registered nurse:

81.17 (1) hospital services;

81.18 (2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions,
81.19 other than dental, which are rendered by a physician or advanced practice registered nurse
81.20 or at the physician's or advanced practice registered nurse's direction;

81.21 (3) drugs requiring a physician's or advanced practice registered nurse's prescription;

81.22 (4) services of a nursing home for not more than 120 days in a year if the services would
81.23 qualify as reimbursable services under Medicare;

81.24 (5) services of a home health agency if the services would qualify as reimbursable
81.25 services under Medicare;

81.26 (6) use of radium or other radioactive materials;

81.27 (7) oxygen;

81.28 (8) anesthetics;

81.29 (9) prostheses other than dental but including scalp hair prostheses worn for hair loss
81.30 suffered as a result of alopecia areata;

82.1 (10) rental or purchase, as appropriate, of durable medical equipment other than
82.2 eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

82.3 (11) diagnostic x-rays and laboratory tests;

82.4 (12) oral surgery for partially or completely unerupted impacted teeth, a tooth root
82.5 without the extraction of the entire tooth, or the gums and tissues of the mouth when not
82.6 performed in connection with the extraction or repair of teeth;

82.7 (13) services of a physical therapist;

82.8 (14) transportation provided by licensed ambulance service to the nearest facility qualified
82.9 to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis
82.10 center for treatment; and

82.11 (15) services of an occupational therapist.

82.12 (c) Covered expenses for the services and articles specified in this subdivision do not
82.13 include the following:

82.14 (1) any charge for care for injury or disease either (i) arising out of an injury in the course
82.15 of employment and subject to a workers' compensation or similar law, (ii) for which benefits
82.16 are payable without regard to fault under coverage statutorily required to be contained in
82.17 any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii)
82.18 for which benefits are payable under another policy of accident and health insurance,
82.19 Medicare, or any other governmental program except as otherwise provided by section
82.20 62A.04, subdivision 3, clause (4);

82.21 (2) any charge for treatment for cosmetic purposes other than for reconstructive surgery
82.22 when such service is incidental to or follows surgery resulting from injury, sickness, or
82.23 other diseases of the involved part or when such service is performed on a covered dependent
82.24 child because of congenital disease or anomaly which has resulted in a functional defect as
82.25 determined by the attending physician or advanced practice registered nurse;

82.26 (3) care which is primarily for custodial or domiciliary purposes which would not qualify
82.27 as eligible services under Medicare;

82.28 (4) any charge for confinement in a private room to the extent it is in excess of the
82.29 institution's charge for its most common semiprivate room, unless a private room is prescribed
82.30 as medically necessary by a physician or advanced practice registered nurse, provided,
82.31 however, that if the institution does not have semiprivate rooms, its most common semiprivate
82.32 room charge shall be considered to be 90 percent of its lowest private room charge;

83.1 (5) that part of any charge for services or articles rendered or prescribed by a physician,
83.2 advanced practice registered nurse, dentist, or other health care personnel which exceeds
83.3 the prevailing charge in the locality where the service is provided; and

83.4 (6) any charge for services or articles the provision of which is not within the scope of
83.5 authorized practice of the institution or individual rendering the services or articles.

83.6 (d) The minimum benefits for a qualified plan shall include, in addition to those benefits
83.7 specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject
83.8 to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

83.9 (e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in
83.10 addition to those benefits specified in clause (a), a second opinion from a physician on all
83.11 surgical procedures expected to cost a total of \$500 or more in physician, laboratory, and
83.12 hospital fees, provided that the coverage need not include the repetition of any diagnostic
83.13 tests.

83.14 (f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in
83.15 addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary
83.16 treatment for phenylketonuria when recommended by a physician or advanced practice
83.17 registered nurse.

83.18 (g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

83.19 Sec. 3. Minnesota Statutes 2018, section 62J.17, subdivision 4a, is amended to read:

83.20 Subd. 4a. **Expenditure reporting.** Each hospital, outpatient surgical center, diagnostic
83.21 imaging center, and physician or advanced practice registered nurse clinic shall report
83.22 annually to the commissioner on all major spending commitments, in the form and manner
83.23 specified by the commissioner. The report shall include the following information:

83.24 (1) a description of major spending commitments made during the previous year,
83.25 including the total dollar amount of major spending commitments and purpose of the
83.26 expenditures;

83.27 (2) the cost of land acquisition, construction of new facilities, and renovation of existing
83.28 facilities;

83.29 (3) the cost of purchased or leased medical equipment, by type of equipment;

83.30 (4) expenditures by type for specialty care and new specialized services;

83.31 (5) information on the amount and types of added capacity for diagnostic imaging
83.32 services, outpatient surgical services, and new specialized services; and

84.1 (6) information on investments in electronic medical records systems.

84.2 For hospitals and outpatient surgical centers, this information shall be included in reports
84.3 to the commissioner that are required under section 144.698. For diagnostic imaging centers,
84.4 this information shall be included in reports to the commissioner that are required under
84.5 section 144.565. For all other health care providers that are subject to this reporting
84.6 requirement, reports must be submitted to the commissioner by March 1 each year for the
84.7 preceding calendar year.

84.8 Sec. 4. Minnesota Statutes 2019 Supplement, section 62J.23, subdivision 2, is amended
84.9 to read:

84.10 Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner
84.11 under this section, the restrictions in the federal Medicare antikickback statutes in section
84.12 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and
84.13 rules adopted under the federal statutes, apply to all persons in the state, regardless of whether
84.14 the person participates in any state health care program.

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

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

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

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

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

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

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

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

85.6 (2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan
85.7 company, or pharmacy benefit manager providing to a patient, at a discount or reduced
85.8 price or free of charge, ancillary products necessary for treatment of the medical condition
85.9 for which the prescription drug, medical supply, or medical equipment was prescribed or
85.10 provided; and

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

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

85.17 Sec. 5. Minnesota Statutes 2018, section 62J.495, subdivision 1a, is amended to read:

85.18 Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an
85.19 electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act
85.20 to meet the standards and implementation specifications adopted under section 3004 as
85.21 applicable.

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

85.23 (c) "Pharmaceutical electronic data intermediary" means any entity that provides the
85.24 infrastructure to connect computer systems or other electronic devices utilized by prescribing
85.25 practitioners with those used by pharmacies, health plans, third-party administrators, and
85.26 pharmacy benefit managers in order to facilitate the secure transmission of electronic
85.27 prescriptions, refill authorization requests, communications, and other prescription-related
85.28 information between such entities.

85.29 (d) "HITECH Act" means the Health Information Technology for Economic and Clinical
85.30 Health Act in division A, title XIII and division B, title IV of the American Recovery and
85.31 Reinvestment Act of 2009, including federal regulations adopted under that act.

86.1 (e) "Interoperable electronic health record" means an electronic health record that securely
86.2 exchanges health information with another electronic health record system that meets
86.3 requirements specified in subdivision 3, and national requirements for certification under
86.4 the HITECH Act.

86.5 (f) "Qualified electronic health record" means an electronic record of health-related
86.6 information on an individual that includes patient demographic and clinical health information
86.7 and has the capacity to:

86.8 (1) provide clinical decision support;

86.9 (2) support ~~physician~~ provider order entry;

86.10 (3) capture and query information relevant to health care quality; and

86.11 (4) exchange electronic health information with, and integrate such information from,
86.12 other sources.

86.13 Sec. 6. Minnesota Statutes 2018, section 62J.52, subdivision 2, is amended to read:

86.14 Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all
86.15 noninstitutional health care services rendered by providers in Minnesota except dental or
86.16 pharmacy providers, that are not currently being billed using an equivalent electronic billing
86.17 format, must be billed using the most current version of the health insurance claim form
86.18 CMS 1500.

86.19 (b) The instructions and definitions for the use of the uniform billing form CMS 1500
86.20 shall be in accordance with the manual developed by the Administrative Uniformity
86.21 Committee entitled standards for the use of the CMS 1500 form, dated February 1994, as
86.22 further defined by the commissioner.

86.23 (c) Services to be billed using the uniform billing form CMS 1500 include physician
86.24 services and supplies, durable medical equipment, noninstitutional ambulance services,
86.25 independent ancillary services including occupational therapy, physical therapy, speech
86.26 therapy and audiology, home infusion therapy, podiatry services, optometry services, mental
86.27 health licensed professional services, substance abuse licensed professional services, ~~nursing~~
86.28 ~~practitioner professional services, certified registered nurse anesthetists~~ advanced practice
86.29 registered nurse services, chiropractors, physician assistants, laboratories, medical suppliers,
86.30 waived services, personal care attendants, and other health care providers such as day
86.31 activity centers and freestanding ambulatory surgical centers.

87.1 (d) Services provided by Medicare Critical Access Hospitals electing Method II billing
87.2 will be allowed an exception to this provision to allow the inclusion of the professional fees
87.3 on the CMS 1450.

87.4 Sec. 7. Minnesota Statutes 2018, section 62J.823, subdivision 3, is amended to read:

87.5 Subd. 3. **Applicability and scope.** Any hospital, as defined in section 144.696,
87.6 subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4,
87.7 shall provide a written estimate of the cost of a specific service or stay upon the request of
87.8 a patient, doctor, advanced practice registered nurse, or the patient's representative. The
87.9 request must include:

87.10 (1) the health coverage status of the patient, including the specific health plan or other
87.11 health coverage under which the patient is enrolled, if any; and

87.12 (2) at least one of the following:

87.13 (i) the specific diagnostic-related group code;

87.14 (ii) the name of the procedure or procedures to be performed;

87.15 (iii) the type of treatment to be received; or

87.16 (iv) any other information that will allow the hospital or outpatient surgical center to
87.17 determine the specific diagnostic-related group or procedure code or codes.

87.18 Sec. 8. Minnesota Statutes 2019 Supplement, section 62Q.184, subdivision 1, is amended
87.19 to read:

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

87.22 (b) "Clinical practice guideline" means a systematically developed statement to assist
87.23 health care providers and enrollees in making decisions about appropriate health care services
87.24 for specific clinical circumstances and conditions developed independently of a health plan
87.25 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical
87.26 practice guideline also includes a preferred drug list developed in accordance with section
87.27 256B.0625.

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

88.1 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but
88.2 also includes a county-based purchasing plan participating in a public program under chapter
88.3 256B or 256L and an integrated health partnership under section 256B.0755.

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

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

88.12 Sec. 9. Minnesota Statutes 2018, section 62Q.43, subdivision 1, is amended to read:

88.13 Subdivision 1. **Closed-panel health plan.** For purposes of this section, "closed-panel
88.14 health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to
88.15 receive all or a majority of primary care services from a specific clinic or ~~physician~~ primary
88.16 care provider designated by the enrollee that is within the health plan company's clinic or
88.17 ~~physician~~ provider network.

88.18 Sec. 10. Minnesota Statutes 2018, section 62Q.43, subdivision 2, is amended to read:

88.19 Subd. 2. **Access requirement.** Every closed-panel health plan must allow enrollees
88.20 under the age of 26 years to change their designated clinic or ~~physician~~ primary care provider
88.21 at least once per month, as long as the clinic or ~~physician~~ provider is part of the health plan
88.22 company's statewide clinic or ~~physician~~ provider network. A health plan company shall not
88.23 charge enrollees who choose this option higher premiums or cost sharing than would
88.24 otherwise apply to enrollees who do not choose this option. A health plan company may
88.25 require enrollees to provide 15 days' written notice of intent to change their designated clinic
88.26 or ~~physician~~ primary care provider.

88.27 Sec. 11. Minnesota Statutes 2018, section 62Q.54, is amended to read:

88.28 **62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.**

88.29 If an enrollee is a resident of a health care facility licensed under chapter 144A or a
88.30 housing with services establishment registered under chapter 144D, the enrollee's primary
88.31 care ~~physician~~ provider must refer the enrollee to that facility's skilled nursing unit or that

89.1 facility's appropriate care setting, provided that the health plan company and the provider
89.2 can best meet the patient's needs in that setting, if the following conditions are met:

89.3 (1) the facility agrees to be reimbursed at that health plan company's contract rate
89.4 negotiated with similar providers for the same services and supplies; and

89.5 (2) the facility meets all guidelines established by the health plan company related to
89.6 quality of care, utilization, referral authorization, risk assumption, use of health plan company
89.7 network, and other criteria applicable to providers under contract for the same services and
89.8 supplies.

89.9 Sec. 12. Minnesota Statutes 2018, section 62Q.57, subdivision 1, is amended to read:

89.10 Subdivision 1. **Choice of primary care provider.** (a) If a health plan company offering
89.11 a group health plan, or an individual health plan that is not a grandfathered plan, requires
89.12 or provides for the designation by an enrollee of a participating primary care provider, the
89.13 health plan company shall permit each enrollee to:

89.14 (1) designate any participating primary care provider available to accept the enrollee;
89.15 and

89.16 (2) for a child, designate any participating physician or advanced practice registered
89.17 nurse who specializes in pediatrics as the child's primary care provider and is available to
89.18 accept the child.

89.19 (b) This section does not waive any exclusions of coverage under the terms and conditions
89.20 of the health plan with respect to coverage of pediatric care.

89.21 Sec. 13. Minnesota Statutes 2018, section 62Q.73, subdivision 7, is amended to read:

89.22 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse
89.23 determination that does not require a medical necessity determination, the external review
89.24 must be based on whether the adverse determination was in compliance with the enrollee's
89.25 health benefit plan.

89.26 (b) For an external review of any issue in an adverse determination by a health plan
89.27 company licensed under chapter 62D that requires a medical necessity determination, the
89.28 external review must determine whether the adverse determination was consistent with the
89.29 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

89.30 (c) For an external review of any issue in an adverse determination by a health plan
89.31 company, other than a health plan company licensed under chapter 62D, that requires a

90.1 medical necessity determination, the external review must determine whether the adverse
 90.2 determination was consistent with the definition of medically necessary care in section
 90.3 62Q.53, subdivision 2.

90.4 (d) For an external review of an adverse determination involving experimental or
 90.5 investigational treatment, the external review entity must base its decision on all documents
 90.6 submitted by the health plan company and enrollee, including medical records, the attending
 90.7 physician, advanced practice registered nurse, or health care professional's recommendation,
 90.8 consulting reports from health care professionals, the terms of coverage, federal Food and
 90.9 Drug Administration approval, and medical or scientific evidence or evidence-based
 90.10 standards.

90.11 Sec. 14. Minnesota Statutes 2018, section 62Q.733, subdivision 3, is amended to read:

90.12 Subd. 3. **Health care provider or provider.** "Health care provider" or "provider" means
 90.13 a physician, advanced practice registered nurse, chiropractor, dentist, podiatrist, or other
 90.14 provider as defined under section 62J.03, other than hospitals, ambulatory surgical centers,
 90.15 or freestanding emergency rooms.

90.16 Sec. 15. Minnesota Statutes 2018, section 62Q.74, subdivision 1, is amended to read:

90.17 Subdivision 1. **Definitions.** (a) For purposes of this section, "category of coverage"
 90.18 means one of the following types of health-related coverage:

90.19 (1) health;

90.20 (2) no-fault automobile medical benefits; or

90.21 (3) workers' compensation medical benefits.

90.22 (b) "Health care provider" or "provider" means a physician, advanced practice registered
 90.23 nurse, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding
 90.24 emergency room, or other provider, as defined in section 62J.03.

90.25 Sec. 16. Minnesota Statutes 2018, section 62S.08, subdivision 3, is amended to read:

90.26 Subd. 3. **Mandatory format.** The following standard format outline of coverage must
 90.27 be used, unless otherwise specifically indicated:

90.28 COMPANY NAME

90.29 ADDRESS - CITY AND STATE

90.30 TELEPHONE NUMBER

90.31 LONG-TERM CARE INSURANCE

91.1 OUTLINE OF COVERAGE

91.2 Policy Number or Group Master Policy and Certificate Number

91.3 (Except for policies or certificates which are guaranteed issue, the following caution
91.4 statement, or language substantially similar, must appear as follows in the outline of
91.5 coverage.)

91.6 CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based
91.7 upon your responses to the questions on your application. A copy of your (application)
91.8 (enrollment form) (is enclosed) (was retained by you when you applied). If your answers
91.9 are incorrect or untrue, the company has the right to deny benefits or rescind your policy.
91.10 The best time to clear up any questions is now, before a claim arises. If, for any reason, any
91.11 of your answers are incorrect, contact the company at this address: (insert address).

91.12 (1) This policy is (an individual policy of insurance) (a group policy) which was issued
91.13 in the (indicate jurisdiction in which group policy was issued).

91.14 (2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a
91.15 very brief description of the important features of the policy. You should compare this
91.16 outline of coverage to outlines of coverage for other policies available to you. This is not
91.17 an insurance contract, but only a summary of coverage. Only the individual or group policy
91.18 contains governing contractual provisions. This means that the policy or group policy sets
91.19 forth in detail the rights and obligations of both you and the insurance company. Therefore,
91.20 if you purchase this coverage, or any other coverage, it is important that you READ YOUR
91.21 POLICY (OR CERTIFICATE) CAREFULLY.

91.22 (3) THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE
91.23 INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE
91.24 INTERNAL REVENUE CODE OF 1986.

91.25 (4) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE
91.26 CONTINUED IN FORCE OR DISCONTINUED.

91.27 (a) (For long-term care health insurance policies or certificates describe one of the
91.28 following permissible policy renewability provisions:)

91.29 (1) (Policies and certificates that are guaranteed renewable shall contain the following
91.30 statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED
91.31 RENEWABLE. This means you have the right, subject to the terms of your policy,
91.32 (certificate) to continue this policy as long as you pay your premiums on time. (Company

92.1 name) cannot change any of the terms of your policy on its own, except that, in the future,
92.2 IT MAY INCREASE THE PREMIUM YOU PAY.

92.3 (2) (Policies and certificates that are noncancelable shall contain the following statement:)
92.4 RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELABLE. This means
92.5 that you have the right, subject to the terms of your policy, to continue this policy as long
92.6 as you pay your premiums on time. (Company name) cannot change any of the terms of
92.7 your policy on its own and cannot change the premium you currently pay. However, if your
92.8 policy contains an inflation protection feature where you choose to increase your benefits,
92.9 (company name) may increase your premium at that time for those additional benefits.

92.10 (b) (For group coverage, specifically describe continuation/conversion provisions
92.11 applicable to the certificate and group policy.)

92.12 (c) (Describe waiver of premium provisions or state that there are not such provisions.)

92.13 (5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

92.14 (In bold type larger than the maximum type required to be used for the other provisions
92.15 of the outline of coverage, state whether or not the company has a right to change the
92.16 premium and, if a right exists, describe clearly and concisely each circumstance under which
92.17 the premium may change.)

92.18 (6) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED
92.19 AND PREMIUM REFUNDED.

92.20 (a) (Provide a brief description of the right to return -- "free look" provision of the policy.)

92.21 (b) (Include a statement that the policy either does or does not contain provisions
92.22 providing for a refund or partial refund of premium upon the death of an insured or surrender
92.23 of the policy or certificate. If the policy contains such provisions, include a description of
92.24 them.)

92.25 (7) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for
92.26 Medicare, review the Medicare Supplement Buyer's Guide available from the insurance
92.27 company.

92.28 (a) (For agents) neither (insert company name) nor its agents represent Medicare, the
92.29 federal government, or any state government.

92.30 (b) (For direct response) (insert company name) is not representing Medicare, the federal
92.31 government, or any state government.

93.1 (8) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide
93.2 coverage for one or more necessary or medically necessary diagnostic, preventive,
93.3 therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting
93.4 other than an acute care unit of a hospital, such as in a nursing home, in the community, or
93.5 in the home.

93.6 This policy provides coverage in the form of a fixed dollar indemnity benefit for covered
93.7 long-term care expenses, subject to policy (limitations), (waiting periods), and (coinsurance)
93.8 requirements. (Modify this paragraph if the policy is not an indemnity policy.)

93.9 (9) BENEFITS PROVIDED BY THIS POLICY.

93.10 (a) (Covered services, related deductible(s), waiting periods, elimination periods, and
93.11 benefit maximums.)

93.12 (b) (Institutional benefits, by skill level.)

93.13 (c) (Noninstitutional benefits, by skill level.)

93.14 (d) (Eligibility for payment of benefits.)

93.15 (Activities of daily living and cognitive impairment shall be used to measure an insured's
93.16 need for long-term care and must be defined and described as part of the outline of coverage.)

93.17 (Any benefit screens must be explained in this section. If these screens differ for different
93.18 benefits, explanation of the screen should accompany each benefit description. If an attending
93.19 physician, advanced practice registered nurse, or other specified person must certify a certain
93.20 level of functional dependency in order to be eligible for benefits, this too must be specified.
93.21 If activities of daily living (ADLs) are used to measure an insured's need for long-term care,
93.22 then these qualifying criteria or screens must be explained.)

93.23 (10) LIMITATIONS AND EXCLUSIONS:

93.24 Describe:

93.25 (a) preexisting conditions;

93.26 (b) noneligible facilities/provider;

93.27 (c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by
93.28 a family member, etc.);

93.29 (d) exclusions/exceptions; and

93.30 (e) limitations.

94.1 (This section should provide a brief specific description of any policy provisions which
94.2 limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of
94.3 the benefits described in paragraph (8).)

94.4 THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH
94.5 YOUR LONG-TERM CARE NEEDS.

94.6 (11) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of
94.7 long-term care services will likely increase over time, you should consider whether and
94.8 how the benefits of this plan may be adjusted. As applicable, indicate the following:

94.9 (a) that the benefit level will not increase over time;

94.10 (b) any automatic benefit adjustment provisions;

94.11 (c) whether the insured will be guaranteed the option to buy additional benefits and the
94.12 basis upon which benefits will be increased over time if not by a specified amount or
94.13 percentage;

94.14 (d) if there is such a guarantee, include whether additional underwriting or health
94.15 screening will be required, the frequency and amounts of the upgrade options, and any
94.16 significant restrictions or limitations; and

94.17 (e) whether there will be any additional premium charge imposed and how that is to be
94.18 calculated.

94.19 (12) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. (State
94.20 that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's
94.21 disease or related degenerative and dementing illnesses. Specifically, describe each benefit
94.22 screen or other policy provision which provides preconditions to the availability of policy
94.23 benefits for such an insured.)

94.24 (13) PREMIUM.

94.25 (a) State the total annual premium for the policy.

94.26 (b) If the premium varies with an applicant's choice among benefit options, indicate the
94.27 portion of annual premium which corresponds to each benefit option.

94.28 (14) ADDITIONAL FEATURES.

94.29 (a) Indicate if medical underwriting is used.

94.30 (b) Describe other important features.

95.1 (15) CONTACT THE STATE DEPARTMENT OF COMMERCE OR SENIOR
95.2 LINKAGE LINE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM
95.3 CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE
95.4 SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE
95.5 POLICY OR CERTIFICATE.

95.6 Sec. 17. Minnesota Statutes 2018, section 62S.20, subdivision 5b, is amended to read:

95.7 Subd. 5b. **Benefit triggers.** Activities of daily living and cognitive impairment must be
95.8 used to measure an insured's need for long-term care and must be described in the policy
95.9 or certificate in a separate paragraph and must be labeled "Eligibility for the Payment of
95.10 Benefits." Any additional benefit triggers must also be explained in this section. If these
95.11 triggers differ for different benefits, explanation of the trigger must accompany each benefit
95.12 description. If an attending physician, advanced practice registered nurse, or other specified
95.13 person must certify a certain level of functional dependency in order to be eligible for
95.14 benefits, this too shall be specified.

95.15 Sec. 18. Minnesota Statutes 2018, section 62S.21, subdivision 2, is amended to read:

95.16 Subd. 2. **Medication information required.** If an application for long-term care
95.17 insurance contains a question which asks whether the applicant has had medication prescribed
95.18 by a physician or advanced practice registered nurse, it must also ask the applicant to list
95.19 the medication that has been prescribed. If the medications listed in the application were
95.20 known by the insurer, or should have been known at the time of application, to be directly
95.21 related to a medical condition for which coverage would otherwise be denied, then the
95.22 policy or certificate shall not be rescinded for that condition.

95.23 Sec. 19. Minnesota Statutes 2018, section 62S.268, subdivision 1, is amended to read:

95.24 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
95.25 meanings given them:

95.26 (a) "Qualified long-term care services" means services that meet the requirements of
95.27 section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary
95.28 diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services,
95.29 and maintenance or personal care services which are required by a chronically ill individual,
95.30 and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

95.31 (b) "Chronically ill individual" has the meaning prescribed for this term by section
95.32 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a

96.1 chronically ill individual means any individual who has been certified by a licensed health
96.2 care practitioner as being unable to perform, without substantial assistance from another
96.3 individual, at least two activities of daily living for a period of at least 90 days due to a loss
96.4 of functional capacity, or requiring substantial supervision to protect the individual from
96.5 threats to health and safety due to severe cognitive impairment.

96.6 The term "chronically ill individual" does not include an individual otherwise meeting
96.7 these requirements unless within the preceding 12-month period a licensed health care
96.8 practitioner has certified that the individual meets these requirements.

96.9 (c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1)
96.10 of the Social Security Act, an advanced practice registered nurse, a registered professional
96.11 nurse, licensed social worker, or other individual who meets requirements prescribed by
96.12 the Secretary of the Treasury.

96.13 (d) "Maintenance or personal care services" means any care the primary purpose of
96.14 which is the provision of needed assistance with any of the disabilities as a result of which
96.15 the individual is a chronically ill individual, including the protection from threats to health
96.16 and safety due to severe cognitive impairment.

96.17 Sec. 20. Minnesota Statutes 2018, section 144.3345, subdivision 1, is amended to read:

96.18 Subdivision 1. **Definitions.** (a) The following definitions are used for the purposes of
96.19 this section.

96.20 (b) "Eligible community e-health collaborative" means an existing or newly established
96.21 collaborative to support the adoption and use of interoperable electronic health records. A
96.22 collaborative must consist of at least two or more eligible health care entities in at least two
96.23 of the categories listed in paragraph (c) and have a focus on interconnecting the members
96.24 of the collaborative for secure and interoperable exchange of health care information.

96.25 (c) "Eligible health care entity" means one of the following:

96.26 (1) community clinics, as defined under section 145.9268;

96.27 (2) hospitals eligible for rural hospital capital improvement grants, as defined in section
96.28 144.148;

96.29 (3) physician or advanced practice registered nurse clinics located in a community with
96.30 a population of less than 50,000 according to United States Census Bureau statistics and
96.31 outside the seven-county metropolitan area;

96.32 (4) nursing facilities licensed under sections 144A.01 to 144A.27;

97.1 (5) community health boards as established under chapter 145A;

97.2 (6) nonprofit entities with a purpose to provide health information exchange coordination
97.3 governed by a representative, multi-stakeholder board of directors; and

97.4 (7) other providers of health or health care services approved by the commissioner for
97.5 which interoperable electronic health record capability would improve quality of care,
97.6 patient safety, or community health.

97.7 Sec. 21. Minnesota Statutes 2018, section 144.3352, is amended to read:

97.8 **144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT**
97.9 **IMMUNIZATION.**

97.10 The commissioner of health or a community health board may inform the physician or
97.11 advanced practice registered nurse attending a newborn of the hepatitis B infection status
97.12 of the biological mother.

97.13 Sec. 22. Minnesota Statutes 2018, section 144.34, is amended to read:

97.14 **144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.**

97.15 Any physician or advanced practice registered nurse having under professional care any
97.16 person whom the physician or advanced practice registered nurse believes to be suffering
97.17 from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas,
97.18 wood alcohol, or mercury, or their compounds, or from anthrax or from compressed-air
97.19 illness or any other disease contracted as a result of the nature of the employment of such
97.20 person shall within five days mail to the Department of Health a report stating the name,
97.21 address, and occupation of such patient, the name, address, and business of the patient's
97.22 employer, the nature of the disease, and such other information as may reasonably be required
97.23 by the department. The department shall prepare and furnish the physicians and advanced
97.24 practice registered nurses of this state suitable blanks for the reports herein required. No
97.25 report made pursuant to the provisions of this section shall be admissible as evidence of the
97.26 facts therein stated in any action at law or in any action under the Workers' Compensation
97.27 Act against any employer of such diseased person. The Department of Health is authorized
97.28 to investigate and to make recommendations for the elimination or prevention of occupational
97.29 diseases which have been reported to it, or which shall be reported to it, in accordance with
97.30 the provisions of this section. The department is also authorized to study and provide advice
97.31 in regard to conditions that may be suspected of causing occupational diseases. Information
97.32 obtained upon investigations made in accordance with the provisions of this section shall
97.33 not be admissible as evidence in any action at law to recover damages for personal injury

98.1 or in any action under the Workers' Compensation Act. Nothing herein contained shall be
98.2 construed to interfere with or limit the powers of the Department of Labor and Industry to
98.3 make inspections of places of employment or issue orders for the protection of the health
98.4 of the persons therein employed. When upon investigation the commissioner of health
98.5 reaches a conclusion that a condition exists which is dangerous to the life and health of the
98.6 workers in any industry or factory or other industrial institutions the commissioner shall
98.7 file a report thereon with the Department of Labor and Industry.

98.8 Sec. 23. Minnesota Statutes 2018, section 144.441, subdivision 4, is amended to read:

98.9 Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision
98.10 2, a person employed by the designated school or school district shall submit to the
98.11 administrator or other person having general control and supervision of the school one of
98.12 the following:

98.13 (1) a statement from a physician, advanced practice registered nurse, or public clinic
98.14 stating that the person has had a negative Mantoux test reaction within the past year, provided
98.15 that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure
98.16 to active tuberculosis;

98.17 (2) a statement from a physician, advanced practice registered nurse, or public clinic
98.18 stating that a person who has a positive Mantoux test reaction has had a negative chest
98.19 roentgenogram (X-ray) for tuberculosis within the past year, provided that the person has
98.20 no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

98.21 (3) a statement from a physician, advanced practice registered nurse, or public health
98.22 clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii)
98.23 is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy
98.24 for active tuberculosis and the person's presence in a school building will not endanger the
98.25 health of other people; or (iv) has completed a course of preventive therapy or was intolerant
98.26 to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or
98.27 evidence of a new exposure to active tuberculosis; or

98.28 (4) a notarized statement signed by the person stating that the person has not submitted
98.29 the proof of tuberculosis screening as required by this subdivision because of conscientiously
98.30 held beliefs. This statement must be forwarded to the commissioner of health.

98.31 Sec. 24. Minnesota Statutes 2018, section 144.441, subdivision 5, is amended to read:

98.32 Subd. 5. **Exceptions.** Subdivisions 3 and 4 do not apply to:

99.1 (1) a person with a history of either a past positive Mantoux test reaction or active
99.2 tuberculosis who has a documented history of completing a course of tuberculosis therapy
99.3 or preventive therapy when the school or school district holds a statement from a physician,
99.4 advanced practice registered nurse, or public health clinic indicating that such therapy was
99.5 provided to the person and that the person has no symptoms suggestive of tuberculosis or
99.6 evidence of a new exposure to active tuberculosis; and

99.7 (2) a person with a history of a past positive Mantoux test reaction who has not completed
99.8 a course of preventive therapy. This determination shall be made by the commissioner based
99.9 on currently accepted public health standards and the person's health status.

99.10 Sec. 25. Minnesota Statutes 2018, section 144.442, subdivision 1, is amended to read:

99.11 Subdivision 1. **Administration; notification.** In the event that the commissioner
99.12 designates a school or school district under section 144.441, subdivision 2, the school or
99.13 school district or community health board may administer Mantoux screening tests to some
99.14 or all persons enrolled in or employed by the designated school or school district. Any
99.15 Mantoux screening provided under this section shall be under the direction of a licensed
99.16 physician or advanced practice registered nurse.

99.17 Prior to administering the Mantoux test to such persons, the school or school district or
99.18 community health board shall inform in writing such persons and parents or guardians of
99.19 minor children to whom the test may be administered, of the following:

99.20 (1) that there has been an occurrence of active tuberculosis or evidence of a higher than
99.21 expected prevalence of tuberculosis infection in that school or school district;

99.22 (2) that screening is necessary to avoid the spread of tuberculosis;

99.23 (3) the manner by which tuberculosis is transmitted;

99.24 (4) the risks and possible side effects of the Mantoux test;

99.25 (5) the risks from untreated tuberculosis to the infected person and others;

99.26 (6) the ordinary course of further diagnosis and treatment if the Mantoux test is positive;

99.27 (7) that screening has been scheduled; and

99.28 (8) that no person will be required to submit to the screening if the person submits a
99.29 statement of objection due to the conscientiously held beliefs of the person employed or of
99.30 the parent or guardian of a minor child.

100.1 Sec. 26. Minnesota Statutes 2018, section 144.4803, subdivision 1, is amended to read:

100.2 Subdivision 1. **Active tuberculosis.** "Active tuberculosis" includes infectious and
100.3 noninfectious tuberculosis and means:

100.4 (1) a condition evidenced by a positive culture for mycobacterium tuberculosis taken
100.5 from a pulmonary or laryngeal source;

100.6 (2) a condition evidenced by a positive culture for mycobacterium tuberculosis taken
100.7 from an extrapulmonary source when there is clinical evidence such as a positive skin test
100.8 for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible
100.9 with pulmonary tuberculosis; or

100.10 (3) a condition in which clinical specimens are not available for culture, but there is
100.11 radiographic evidence of tuberculosis such as an abnormal chest x-ray, and clinical evidence
100.12 such as a positive skin test for tuberculosis infection, coughing, sputum production, fever,
100.13 or other symptoms compatible with pulmonary tuberculosis, that lead a physician or advanced
100.14 practice registered nurse to reasonably diagnose active tuberculosis according to currently
100.15 accepted standards of medical practice and to initiate treatment for tuberculosis.

100.16 Sec. 27. Minnesota Statutes 2018, section 144.4803, is amended by adding a subdivision
100.17 to read:

100.18 Subd. 1a. **Advanced practice registered nurse.** "Advanced practice registered nurse"
100.19 means a person who is licensed by the Board of Nursing under chapter 148 to practice as
100.20 an advanced practice registered nurse.

100.21 Sec. 28. Minnesota Statutes 2018, section 144.4803, subdivision 4, is amended to read:

100.22 Subd. 4. **Clinically suspected of having active tuberculosis.** "Clinically suspected of
100.23 having active tuberculosis" means presenting a reasonable possibility of having active
100.24 tuberculosis based upon epidemiologic, clinical, or radiographic evidence, laboratory test
100.25 results, or other reliable evidence as determined by a physician or advanced practice
100.26 registered nurse using currently accepted standards of medical practice.

100.27 Sec. 29. Minnesota Statutes 2018, section 144.4803, subdivision 10, is amended to read:

100.28 Subd. 10. **Endangerment to the public health.** "Endangerment to the public health"
100.29 means a carrier who may transmit tuberculosis to another person or persons because the
100.30 carrier has engaged or is engaging in any of the following conduct:

101.1 (1) refuses or fails to submit to a diagnostic tuberculosis examination that is ordered by
101.2 a physician or advanced practice registered nurse and is reasonable according to currently
101.3 accepted standards of medical practice;

101.4 (2) refuses or fails to initiate or complete treatment for tuberculosis that is prescribed
101.5 by a physician or advanced practice registered nurse and is reasonable according to currently
101.6 accepted standards of medical practice;

101.7 (3) refuses or fails to keep appointments for treatment of tuberculosis;

101.8 (4) refuses or fails to provide the commissioner, upon request, with evidence showing
101.9 the completion of a course of treatment for tuberculosis that is prescribed by a physician or
101.10 advanced practice registered nurse and is reasonable according to currently accepted standards
101.11 of medical practice;

101.12 (5) refuses or fails to initiate or complete a course of directly observed therapy that is
101.13 prescribed by a physician or advanced practice registered nurse and is reasonable according
101.14 to currently accepted standards of medical practice;

101.15 (6) misses at least 20 percent of scheduled appointments for directly observed therapy,
101.16 or misses at least two consecutive appointments for directly observed therapy;

101.17 (7) refuses or fails to follow contagion precautions for tuberculosis after being instructed
101.18 on the precautions by a licensed health professional or by the commissioner;

101.19 (8) based on evidence of the carrier's past or present behavior, may not complete a course
101.20 of treatment for tuberculosis that is reasonable according to currently accepted standards
101.21 of medical practice; or

101.22 (9) may expose other persons to tuberculosis based on epidemiological, medical, or other
101.23 reliable evidence.

101.24 Sec. 30. Minnesota Statutes 2018, section 144.4806, is amended to read:

101.25 **144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.**

101.26 A health order may include, but need not be limited to, an order:

101.27 (1) requiring the carrier's attending physician, advanced practice registered nurse, or
101.28 treatment facility to isolate and detain the carrier for treatment or for a diagnostic examination
101.29 for tuberculosis, pursuant to section 144.4807, subdivision 1, if the carrier is an endangerment
101.30 to the public health and is in a treatment facility;

102.1 (2) requiring a carrier who is an endangerment to the public health to submit to diagnostic
102.2 examination for tuberculosis and to remain in the treatment facility until the commissioner
102.3 receives the results of the examination;

102.4 (3) requiring a carrier who is an endangerment to the public health to remain in or present
102.5 at a treatment facility until the carrier has completed a course of treatment for tuberculosis
102.6 that is prescribed by a physician or advanced practice registered nurse and is reasonable
102.7 according to currently accepted standards of medical practice;

102.8 (4) requiring a carrier who is an endangerment to the public health to complete a course
102.9 of treatment for tuberculosis that is prescribed by a physician or advanced practice registered
102.10 nurse and is reasonable according to currently accepted standards of medical practice and,
102.11 if necessary, to follow contagion precautions for tuberculosis;

102.12 (5) requiring a carrier who is an endangerment to the public health to follow a course
102.13 of directly observed therapy that is prescribed by a physician or advanced practice registered
102.14 nurse and is reasonable according to currently accepted standards of medical practice;

102.15 (6) excluding a carrier who is an endangerment to the public health from the carrier's
102.16 place of work or school, or from other premises if the commissioner determines that exclusion
102.17 is necessary because contagion precautions for tuberculosis cannot be maintained in a
102.18 manner adequate to protect others from being exposed to tuberculosis;

102.19 (7) requiring a licensed health professional or treatment facility to provide to the
102.20 commissioner certified copies of all medical and epidemiological data relevant to the carrier's
102.21 tuberculosis and status as an endangerment to the public health;

102.22 (8) requiring the diagnostic examination for tuberculosis of other persons in the carrier's
102.23 household, workplace, or school, or other persons in close contact with the carrier if the
102.24 commissioner has probable cause to believe that the persons may have active tuberculosis
102.25 or may have been exposed to tuberculosis based on epidemiological, medical, or other
102.26 reliable evidence; or

102.27 (9) requiring a carrier or other persons to follow contagion precautions for tuberculosis.

102.28 Sec. 31. Minnesota Statutes 2018, section 144.4807, subdivision 1, is amended to read:

102.29 Subdivision 1. **Obligation to isolate.** If the carrier is in a treatment facility, the
102.30 commissioner or a carrier's attending physician or advanced practice registered nurse, after
102.31 obtaining approval from the commissioner, may issue a notice of obligation to isolate to a
102.32 treatment facility if the commissioner or attending physician or advanced practice registered
102.33 nurse has probable cause to believe that a carrier is an endangerment to the public health.

103.1 Sec. 32. Minnesota Statutes 2018, section 144.4807, subdivision 2, is amended to read:

103.2 Subd. 2. **Obligation to examine.** If the carrier is clinically suspected of having active
103.3 tuberculosis, the commissioner may issue a notice of obligation to examine to the carrier's
103.4 attending physician or advanced practice registered nurse to conduct a diagnostic examination
103.5 for tuberculosis on the carrier.

103.6 Sec. 33. Minnesota Statutes 2018, section 144.4807, subdivision 4, is amended to read:

103.7 Subd. 4. **Service of health order on carrier.** When issuing a notice of obligation to
103.8 isolate or examine to the carrier's physician or advanced practice registered nurse or a
103.9 treatment facility, the commissioner shall simultaneously serve a health order on the carrier
103.10 ordering the carrier to remain in the treatment facility for treatment or examination.

103.11 Sec. 34. Minnesota Statutes 2018, section 144.50, subdivision 2, is amended to read:

103.12 Subd. 2. **Hospital, sanitarium, other institution; definition.** Hospital, sanitarium or
103.13 other institution for the hospitalization or care of human beings, within the meaning of
103.14 sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which
103.15 any accommodation is maintained, furnished, or offered for five or more persons for: the
103.16 hospitalization of the sick or injured; the provision of care in a swing bed authorized under
103.17 section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients;
103.18 emergency medical services offered 24 hours a day, seven days a week, in an ambulatory
103.19 or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of
103.20 human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's or
103.21 advanced practice registered nurse's office or to hotels or other similar places that furnish
103.22 only board and room, or either, to their guests.

103.23 Sec. 35. Minnesota Statutes 2019 Supplement, section 144.55, subdivision 2, is amended
103.24 to read:

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

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

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

104.3 Sec. 36. Minnesota Statutes 2018, section 144.55, subdivision 6, is amended to read:

104.4 Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may
104.5 refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

104.6 (1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards
104.7 issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

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

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

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

104.11 (5) with respect to hospitals and outpatient surgical centers, if the commissioner
104.12 determines that there is a pattern of conduct that one or more physicians or advanced practice
104.13 registered nurses who have a "financial or economic interest," as defined in section 144.6521,
104.14 subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and
104.15 disclosure of the financial or economic interest required by section 144.6521.

104.16 (b) The commissioner shall not renew a license for a boarding care bed in a resident
104.17 room with more than four beds.

104.18 Sec. 37. Minnesota Statutes 2018, section 144.6501, subdivision 7, is amended to read:

104.19 Subd. 7. **Consent to treatment.** An admission contract must not include a clause
104.20 requiring a resident to sign a consent to all treatment ordered by any physician or advanced
104.21 practice registered nurse. An admission contract may require consent only for routine nursing
104.22 care or emergency care. An admission contract must contain a clause that informs the
104.23 resident of the right to refuse treatment.

104.24 Sec. 38. Minnesota Statutes 2018, section 144.651, subdivision 7, is amended to read:

104.25 Subd. 7. **Physician's or advanced practice registered nurse's identity.** Patients and
104.26 residents shall have or be given, in writing, the name, business address, telephone number,
104.27 and specialty, if any, of the physician or advanced practice registered nurse responsible for
104.28 coordination of their care. In cases where it is medically inadvisable, as documented by the
104.29 attending physician or advanced practice registered nurse in a patient's or resident's care
104.30 record, the information shall be given to the patient's or resident's guardian or other person
104.31 designated by the patient or resident as a representative.

105.1 Sec. 39. Minnesota Statutes 2018, section 144.651, subdivision 8, is amended to read:

105.2 Subd. 8. **Relationship with other health services.** Patients and residents who receive
105.3 services from an outside provider are entitled, upon request, to be told the identity of the
105.4 provider. Residents shall be informed, in writing, of any health care services which are
105.5 provided to those residents by individuals, corporations, or organizations other than their
105.6 facility. Information shall include the name of the outside provider, the address, and a
105.7 description of the service which may be rendered. In cases where it is medically inadvisable,
105.8 as documented by the attending physician or advanced practice registered nurse in a patient's
105.9 or resident's care record, the information shall be given to the patient's or resident's guardian
105.10 or other person designated by the patient or resident as a representative.

105.11 Sec. 40. Minnesota Statutes 2018, section 144.651, subdivision 9, is amended to read:

105.12 Subd. 9. **Information about treatment.** Patients and residents shall be given by their
105.13 physicians or advanced practice registered nurses complete and current information
105.14 concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the
105.15 physician's or advanced practice registered nurse's legal duty to disclose. This information
105.16 shall be in terms and language the patients or residents can reasonably be expected to
105.17 understand. Patients and residents may be accompanied by a family member or other chosen
105.18 representative, or both. This information shall include the likely medical or major
105.19 psychological results of the treatment and its alternatives. In cases where it is medically
105.20 inadvisable, as documented by the attending physician or advanced practice registered nurse
105.21 in a patient's or resident's medical record, the information shall be given to the patient's or
105.22 resident's guardian or other person designated by the patient or resident as a representative.
105.23 Individuals have the right to refuse this information.

105.24 Every patient or resident suffering from any form of breast cancer shall be fully informed,
105.25 prior to or at the time of admission and during her stay, of all alternative effective methods
105.26 of treatment of which the treating physician or advanced practice registered nurse is
105.27 knowledgeable, including surgical, radiological, or chemotherapeutic treatments or
105.28 combinations of treatments and the risks associated with each of those methods.

105.29 Sec. 41. Minnesota Statutes 2018, section 144.651, subdivision 10, is amended to read:

105.30 Subd. 10. **Participation in planning treatment; notification of family members.** (a)
105.31 Patients and residents shall have the right to participate in the planning of their health care.
105.32 This right includes the opportunity to discuss treatment and alternatives with individual
105.33 caregivers, the opportunity to request and participate in formal care conferences, and the

106.1 right to include a family member or other chosen representative, or both. In the event that
106.2 the patient or resident cannot be present, a family member or other representative chosen
106.3 by the patient or resident may be included in such conferences. A chosen representative
106.4 may include a doula of the patient's choice.

106.5 (b) If a patient or resident who enters a facility is unconscious or comatose or is unable
106.6 to communicate, the facility shall make reasonable efforts as required under paragraph (c)
106.7 to notify either a family member or a person designated in writing by the patient as the
106.8 person to contact in an emergency that the patient or resident has been admitted to the
106.9 facility. The facility shall allow the family member to participate in treatment planning,
106.10 unless the facility knows or has reason to believe the patient or resident has an effective
106.11 advance directive to the contrary or knows the patient or resident has specified in writing
106.12 that they do not want a family member included in treatment planning. After notifying a
106.13 family member but prior to allowing a family member to participate in treatment planning,
106.14 the facility must make reasonable efforts, consistent with reasonable medical practice, to
106.15 determine if the patient or resident has executed an advance directive relative to the patient
106.16 or resident's health care decisions. For purposes of this paragraph, "reasonable efforts"
106.17 include:

106.18 (1) examining the personal effects of the patient or resident;

106.19 (2) examining the medical records of the patient or resident in the possession of the
106.20 facility;

106.21 (3) inquiring of any emergency contact or family member contacted under this section
106.22 whether the patient or resident has executed an advance directive and whether the patient
106.23 or resident has a physician or advanced practice registered nurse to whom the patient or
106.24 resident normally goes for care; and

106.25 (4) inquiring of the physician or advanced practice registered nurse to whom the patient
106.26 or resident normally goes for care, if known, whether the patient or resident has executed
106.27 an advance directive. If a facility notifies a family member or designated emergency contact
106.28 or allows a family member to participate in treatment planning in accordance with this
106.29 paragraph, the facility is not liable to the patient or resident for damages on the grounds
106.30 that the notification of the family member or emergency contact or the participation of the
106.31 family member was improper or violated the patient's privacy rights.

106.32 (c) In making reasonable efforts to notify a family member or designated emergency
106.33 contact, the facility shall attempt to identify family members or a designated emergency
106.34 contact by examining the personal effects of the patient or resident and the medical records

107.1 of the patient or resident in the possession of the facility. If the facility is unable to notify
107.2 a family member or designated emergency contact within 24 hours after the admission, the
107.3 facility shall notify the county social service agency or local law enforcement agency that
107.4 the patient or resident has been admitted and the facility has been unable to notify a family
107.5 member or designated emergency contact. The county social service agency and local law
107.6 enforcement agency shall assist the facility in identifying and notifying a family member
107.7 or designated emergency contact. A county social service agency or local law enforcement
107.8 agency that assists a facility in implementing this subdivision is not liable to the patient or
107.9 resident for damages on the grounds that the notification of the family member or emergency
107.10 contact or the participation of the family member was improper or violated the patient's
107.11 privacy rights.

107.12 Sec. 42. Minnesota Statutes 2018, section 144.651, subdivision 12, is amended to read:

107.13 Subd. 12. **Right to refuse care.** Competent patients and residents shall have the right
107.14 to refuse treatment based on the information required in subdivision 9. Residents who refuse
107.15 treatment, medication, or dietary restrictions shall be informed of the likely medical or major
107.16 psychological results of the refusal, with documentation in the individual medical record.
107.17 In cases where a patient or resident is incapable of understanding the circumstances but has
107.18 not been adjudicated incompetent, or when legal requirements limit the right to refuse
107.19 treatment, the conditions and circumstances shall be fully documented by the attending
107.20 physician or advanced practice registered nurse in the patient's or resident's medical record.

107.21 Sec. 43. Minnesota Statutes 2018, section 144.651, subdivision 14, is amended to read:

107.22 Subd. 14. **Freedom from maltreatment.** Patients and residents shall be free from
107.23 maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means
107.24 conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic
107.25 infliction of physical pain or injury, or any persistent course of conduct intended to produce
107.26 mental or emotional distress. Every patient and resident shall also be free from nontherapeutic
107.27 chemical and physical restraints, except in fully documented emergencies, or as authorized
107.28 in writing after examination by a patient's or resident's physician or advanced practice
107.29 registered nurse for a specified and limited period of time, and only when necessary to
107.30 protect the resident from self-injury or injury to others.

107.31 Sec. 44. Minnesota Statutes 2018, section 144.651, subdivision 31, is amended to read:

107.32 Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a
107.33 residential program as defined in section 253C.01 has the right to be free from physical

108.1 restraint and isolation except in emergency situations involving a likelihood that the patient
108.2 will physically harm the patient's self or others. These procedures may not be used for
108.3 disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation
108.4 or restraint may be used only upon the prior authorization of a physician, advanced practice
108.5 registered nurse, psychiatrist, or licensed psychologist, only when less restrictive measures
108.6 are ineffective or not feasible and only for the shortest time necessary.

108.7 Sec. 45. Minnesota Statutes 2018, section 144.651, subdivision 33, is amended to read:

108.8 Subd. 33. **Restraints.** (a) Competent nursing home residents, family members of residents
108.9 who are not competent, and legally appointed conservators, guardians, and health care agents
108.10 as defined under section 145C.01, have the right to request and consent to the use of a
108.11 physical restraint in order to treat the medical symptoms of the resident.

108.12 (b) Upon receiving a request for a physical restraint, a nursing home shall inform the
108.13 resident, family member, or legal representative of alternatives to and the risks involved
108.14 with physical restraint use. The nursing home shall provide a physical restraint to a resident
108.15 only upon receipt of a signed consent form authorizing restraint use and a written order
108.16 from the attending physician or advanced practice registered nurse that contains statements
108.17 and determinations regarding medical symptoms and specifies the circumstances under
108.18 which restraints are to be used.

108.19 (c) A nursing home providing a restraint under paragraph (b) must:

108.20 (1) document that the procedures outlined in that paragraph have been followed;

108.21 (2) monitor the use of the restraint by the resident; and

108.22 (3) periodically, in consultation with the resident, the family, and the attending physician
108.23 or advanced practice registered nurse, reevaluate the resident's need for the restraint.

108.24 (d) A nursing home shall not be subject to fines, civil money penalties, or other state or
108.25 federal survey enforcement remedies solely as the result of allowing the use of a physical
108.26 restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the
108.27 commissioner from taking action to protect the health and safety of a resident if:

108.28 (1) the use of the restraint has jeopardized the health and safety of the resident; and

108.29 (2) the nursing home failed to take reasonable measures to protect the health and safety
108.30 of the resident.

108.31 (e) For purposes of this subdivision, "medical symptoms" include:

108.32 (1) a concern for the physical safety of the resident; and

109.1 (2) physical or psychological needs expressed by a resident. A resident's fear of falling
109.2 may be the basis of a medical symptom.

109.3 A written order from the attending physician or advanced practice registered nurse that
109.4 contains statements and determinations regarding medical symptoms is sufficient evidence
109.5 of the medical necessity of the physical restraint.

109.6 (f) When determining nursing facility compliance with state and federal standards for
109.7 the use of physical restraints, the commissioner of health is bound by the statements and
109.8 determinations contained in the attending physician's or advanced practice registered nurse's
109.9 order regarding medical symptoms. For purposes of this order, "medical symptoms" include
109.10 the request by a competent resident, family member of a resident who is not competent, or
109.11 legally appointed conservator, guardian, or health care agent as defined under section
109.12 145C.01, that the facility provide a physical restraint in order to enhance the physical safety
109.13 of the resident.

109.14 Sec. 46. Minnesota Statutes 2018, section 144.652, subdivision 2, is amended to read:

109.15 Subd. 2. **Correction order; emergencies.** A substantial violation of the rights of any
109.16 patient or resident as defined in section 144.651, shall be grounds for issuance of a correction
109.17 order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction
109.18 order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf
109.19 of a patient or resident to enforce any unreasonable violation of the patient's or resident's
109.20 rights. Compliance with the provisions of section 144.651 shall not be required whenever
109.21 emergency conditions, as documented by the attending physician or advanced practice
109.22 registered nurse in a patient's medical record or a resident's care record, indicate immediate
109.23 medical treatment, including but not limited to surgical procedures, is necessary and it is
109.24 impossible or impractical to comply with the provisions of section 144.651 because delay
109.25 would endanger the patient's or resident's life, health, or safety.

109.26 Sec. 47. Minnesota Statutes 2018, section 144.69, is amended to read:

109.27 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

109.28 Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data
109.29 collected on individuals by the cancer surveillance system, including the names and personal
109.30 identifiers of persons required in section 144.68 to report, shall be private and may only be
109.31 used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68.
109.32 Any disclosure other than is provided for in this section and sections 144.671, 144.672, and
109.33 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by

110.1 rule, and as part of an epidemiologic investigation, an officer or employee of the
110.2 commissioner of health may interview patients named in any such report, or relatives of
110.3 any such patient, only after the consent of the attending physician, advanced practice
110.4 registered nurse, or surgeon is obtained.

110.5 Sec. 48. Minnesota Statutes 2018, section 144.7402, subdivision 2, is amended to read:

110.6 Subd. 2. **Conditions.** A facility shall follow the procedures outlined in sections 144.7401
110.7 to 144.7415 when all of the following conditions are met:

110.8 (1) the facility determines that significant exposure has occurred, following the protocol
110.9 under section 144.7414;

110.10 (2) the licensed physician or advanced practice registered nurse for the emergency
110.11 medical services person needs the source individual's blood-borne pathogen test results to
110.12 begin, continue, modify, or discontinue treatment, in accordance with the most current
110.13 guidelines of the United States Public Health Service, because of possible exposure to a
110.14 blood-borne pathogen; and

110.15 (3) the emergency medical services person consents to provide a blood sample for testing
110.16 for a blood-borne pathogen. If the emergency medical services person consents to blood
110.17 collection, but does not consent at that time to blood-borne pathogen testing, the facility
110.18 shall preserve the sample for at least 90 days. If the emergency medical services person
110.19 elects to have the sample tested within 90 days, the testing shall be done as soon as feasible.

110.20 Sec. 49. Minnesota Statutes 2018, section 144.7406, subdivision 2, is amended to read:

110.21 Subd. 2. **Procedures without consent.** If the source individual has provided a blood
110.22 sample with consent but does not consent to blood-borne pathogen testing, the facility shall
110.23 test for blood-borne pathogens if the emergency medical services person or emergency
110.24 medical services agency requests the test, provided all of the following criteria are met:

110.25 (1) the emergency medical services person or emergency medical services agency has
110.26 documented exposure to blood or body fluids during performance of that person's occupation
110.27 or while acting as a Good Samaritan under section 604A.01 or executing a citizen's arrest
110.28 under section 629.30;

110.29 (2) the facility has determined that a significant exposure has occurred and a licensed
110.30 physician or advanced practice registered nurse for the emergency medical services person
110.31 has documented in the emergency medical services person's medical record that blood-borne
110.32 pathogen test results are needed for beginning, modifying, continuing, or discontinuing

111.1 medical treatment for the emergency medical services person under section 144.7414,
111.2 subdivision 2;

111.3 (3) the emergency medical services person provides a blood sample for testing for
111.4 blood-borne pathogens as soon as feasible;

111.5 (4) the facility asks the source individual to consent to a test for blood-borne pathogens
111.6 and the source individual does not consent;

111.7 (5) the facility has provided the source individual with all of the information required
111.8 by section 144.7403; and

111.9 (6) the facility has informed the emergency medical services person of the confidentiality
111.10 requirements of section 144.7411 and the penalties for unauthorized release of source
111.11 information under section 144.7412.

111.12 Sec. 50. Minnesota Statutes 2018, section 144.7407, subdivision 2, is amended to read:

111.13 Subd. 2. **Procedures without consent.** (a) An emergency medical services agency, or,
111.14 if there is no agency, an emergency medical services person, may bring a petition for a court
111.15 order to require a source individual to provide a blood sample for testing for blood-borne
111.16 pathogens. The petition shall be filed in the district court in the county where the source
111.17 individual resides or is hospitalized. The petitioner shall serve the petition on the source
111.18 individual at least three days before a hearing on the petition. The petition shall include one
111.19 or more affidavits attesting that:

111.20 (1) the facility followed the procedures in sections 144.7401 to 144.7415 and attempted
111.21 to obtain blood-borne pathogen test results according to those sections;

111.22 (2) it has been determined under section 144.7414, subdivision 2, that a significant
111.23 exposure has occurred to the emergency medical services person; and

111.24 (3) a physician with specialty training in infectious diseases, including HIV, has
111.25 documented that the emergency medical services person has provided a blood sample and
111.26 consented to testing for blood-borne pathogens and blood-borne pathogen test results are
111.27 needed for beginning, continuing, modifying, or discontinuing medical treatment for the
111.28 emergency medical services person.

111.29 (b) Facilities shall cooperate with petitioners in providing any necessary affidavits to
111.30 the extent that facility staff can attest under oath to the facts in the affidavits.

111.31 (c) The court may order the source individual to provide a blood sample for blood-borne
111.32 pathogen testing if:

112.1 (1) there is probable cause to believe the emergency medical services person has
112.2 experienced a significant exposure to the source individual;

112.3 (2) the court imposes appropriate safeguards against unauthorized disclosure that must
112.4 specify the persons who have access to the test results and the purposes for which the test
112.5 results may be used;

112.6 (3) a licensed physician or advanced practice registered nurse for the emergency medical
112.7 services person needs the test results for beginning, continuing, modifying, or discontinuing
112.8 medical treatment for the emergency medical services person; and

112.9 (4) the court finds a compelling need for the test results. In assessing compelling need,
112.10 the court shall weigh the need for the court-ordered blood collection and test results against
112.11 the interests of the source individual, including, but not limited to, privacy, health, safety,
112.12 or economic interests. The court shall also consider whether the involuntary blood collection
112.13 and testing would serve the public interest.

112.14 (d) The court shall conduct the proceeding in camera unless the petitioner or the source
112.15 individual requests a hearing in open court and the court determines that a public hearing
112.16 is necessary to the public interest and the proper administration of justice.

112.17 (e) The court shall conduct an ex parte hearing if the source individual does not attend
112.18 the noticed hearing and the petitioner complied with the notice requirements in paragraph
112.19 (a).

112.20 (f) The source individual has the right to counsel in any proceeding brought under this
112.21 subdivision.

112.22 (g) The court may order a source individual taken into custody by a peace officer for
112.23 purposes of obtaining a blood sample if the source individual does not comply with an order
112.24 issued by the court pursuant to paragraph (c). The source individual shall be held no longer
112.25 than is necessary to secure a blood sample. A person may not be held for more than 24 hours
112.26 without receiving a court hearing.

112.27 Sec. 51. Minnesota Statutes 2018, section 144.7414, subdivision 2, is amended to read:

112.28 Subd. 2. **Facility protocol requirements.** Every facility shall adopt and follow a
112.29 postexposure protocol for emergency medical services persons who have experienced a
112.30 significant exposure. The postexposure protocol must adhere to the most current
112.31 recommendations of the United States Public Health Service and include, at a minimum,
112.32 the following:

113.1 (1) a process for emergency medical services persons to report an exposure in a timely
113.2 fashion;

113.3 (2) a process for an infectious disease specialist, or a licensed physician or advanced
113.4 practice registered nurse who is knowledgeable about the most current recommendations
113.5 of the United States Public Health Service in consultation with an infectious disease specialist,
113.6 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
113.7 occurred and (ii) to provide, under the direction of a licensed physician or advanced practice
113.8 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
113.9 to the particular blood-borne pathogen or pathogens for which a significant exposure has
113.10 been determined;

113.11 (3) if there has been a significant exposure, a process to determine whether the source
113.12 individual has a blood-borne pathogen through disclosure of test results, or through blood
113.13 collection and testing as required by sections 144.7401 to 144.7415;

113.14 (4) a process for providing appropriate counseling prior to and following testing for a
113.15 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
113.16 follow-up recommendations according to the most current recommendations of the United
113.17 States Public Health Service, recommendations for testing, and treatment to the emergency
113.18 medical services person;

113.19 (5) a process for providing appropriate counseling under clause (4) to the emergency
113.20 medical services person and the source individual; and

113.21 (6) compliance with applicable state and federal laws relating to data practices,
113.22 confidentiality, informed consent, and the patient bill of rights.

113.23 Sec. 52. Minnesota Statutes 2018, section 144.7415, subdivision 2, is amended to read:

113.24 Subd. 2. **Immunity.** A facility, licensed physician, advanced practice registered nurse,
113.25 and designated health care personnel are immune from liability in any civil, administrative,
113.26 or criminal action relating to the disclosure of test results to an emergency medical services
113.27 person or emergency medical services agency and the testing of a blood sample from the
113.28 source individual for blood-borne pathogens if a good faith effort has been made to comply
113.29 with sections 144.7401 to 144.7415.

113.30 Sec. 53. Minnesota Statutes 2018, section 144.9502, subdivision 4, is amended to read:

113.31 Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis
113.32 reports required in this section must specify:

- 114.1 (1) whether the specimen was collected as a capillary or venous sample;
- 114.2 (2) the date the sample was collected;
- 114.3 (3) the results of the blood lead analysis;
- 114.4 (4) the date the sample was analyzed;
- 114.5 (5) the method of analysis used;
- 114.6 (6) the full name, address, and phone number of the laboratory performing the analysis;
- 114.7 (7) the full name, address, and phone number of the physician, advanced practice
- 114.8 registered nurse, or facility requesting the analysis;
- 114.9 (8) the full name, address, and phone number of the person with the blood lead level,
- 114.10 and the person's birthdate, gender, and race.

114.11 Sec. 54. Minnesota Statutes 2018, section 144.966, subdivision 3, is amended to read:

114.12 **Subd. 3. Early hearing detection and intervention programs.** All hospitals shall
114.13 establish an early hearing detection and intervention (EHDI) program. Each EHDI program
114.14 shall:

- 114.15 (1) in advance of any hearing screening testing, provide to the newborn's or infant's
114.16 parents or parent information concerning the nature of the screening procedure, applicable
114.17 costs of the screening procedure, the potential risks and effects of hearing loss, and the
114.18 benefits of early detection and intervention;
- 114.19 (2) comply with parental election as described under section 144.125, subdivision 4;
- 114.20 (3) develop policies and procedures for screening and rescreening based on Department
114.21 of Health recommendations;
- 114.22 (4) provide appropriate training and monitoring of individuals responsible for performing
114.23 hearing screening tests as recommended by the Department of Health;
- 114.24 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain
114.25 in the hospital for a prolonged period, testing shall be performed prior to three months of
114.26 age or when medically feasible;
- 114.27 (6) develop and implement procedures for documenting the results of all hearing screening
114.28 tests;
- 114.29 (7) inform the newborn's or infant's parents or parent, primary care physician or advanced
114.30 practice registered nurse, and the Department of Health according to recommendations of

115.1 the Department of Health of the results of the hearing screening test or rescreening if
115.2 conducted, or if the newborn or infant was not successfully tested. The hospital that
115.3 discharges the newborn or infant to home is responsible for the screening; and

115.4 (8) collect performance data specified by the Department of Health.

115.5 Sec. 55. Minnesota Statutes 2018, section 144.966, subdivision 6, is amended to read:

115.6 Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician, advanced
115.7 practice registered nurse, or hospital shall be civilly or criminally liable for failure to conduct
115.8 hearing screening testing.

115.9 (b) No physician, midwife, nurse, other health professional, or hospital acting in
115.10 compliance with this section shall be civilly or criminally liable for any acts conforming
115.11 with this section, including furnishing information required according to this section.

115.12 Sec. 56. Minnesota Statutes 2018, section 144A.135, is amended to read:

115.13 **144A.135 TRANSFER AND DISCHARGE APPEALS.**

115.14 (a) The commissioner shall establish a mechanism for hearing appeals on transfers and
115.15 discharges of residents by nursing homes or boarding care homes licensed by the
115.16 commissioner. The commissioner may adopt permanent rules to implement this section.

115.17 (b) Until federal regulations are adopted under sections 1819(f)(3) and 1919(f)(3) of the
115.18 Social Security Act that govern appeals of the discharges or transfers of residents from
115.19 nursing homes and boarding care homes certified for participation in Medicare or medical
115.20 assistance, the commissioner shall provide hearings under sections 14.57 to 14.62 and the
115.21 rules adopted by the Office of Administrative Hearings governing contested cases. To appeal
115.22 the discharge or transfer, or notification of an intended discharge or transfer, a resident or
115.23 the resident's representative must request a hearing in writing no later than 30 days after
115.24 receiving written notice, which conforms to state and federal law, of the intended discharge
115.25 or transfer.

115.26 (c) Hearings under this section shall be held no later than 14 days after receipt of the
115.27 request for hearing, unless impractical to do so or unless the parties agree otherwise. Hearings
115.28 shall be held in the facility in which the resident resides, unless impractical to do so or unless
115.29 the parties agree otherwise.

115.30 (d) A resident who timely appeals a notice of discharge or transfer, and who resides in
115.31 a certified nursing home or boarding care home, may not be discharged or transferred by
115.32 the nursing home or boarding care home until resolution of the appeal. The commissioner

116.1 can order the facility to readmit the resident if the discharge or transfer was in violation of
116.2 state or federal law. If the resident is required to be hospitalized for medical necessity before
116.3 resolution of the appeal, the facility shall readmit the resident unless the resident's attending
116.4 physician or advanced practice registered nurse documents, in writing, why the resident's
116.5 specific health care needs cannot be met in the facility.

116.6 (e) The commissioner and Office of Administrative Hearings shall conduct the hearings
116.7 in compliance with the federal regulations described in paragraph (b), when adopted.

116.8 (f) Nothing in this section limits the right of a resident or the resident's representative
116.9 to request or receive assistance from the Office of Ombudsman for Long-Term Care or the
116.10 Office of Health Facility Complaints with respect to an intended discharge or transfer.

116.11 (g) A person required to inform a health care facility of the person's status as a registered
116.12 predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so
116.13 shall be deemed to have endangered the safety of individuals in the facility under Code of
116.14 Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal
116.15 of the notice and discharge shall not constitute a stay of the discharge.

116.16 Sec. 57. Minnesota Statutes 2018, section 144A.161, subdivision 5, is amended to read:

116.17 Subd. 5. **Licensee responsibilities related to sending the notice in subdivision 5a.** (a)
116.18 The licensee shall establish an interdisciplinary team responsible for coordinating and
116.19 implementing the plan. The interdisciplinary team shall include representatives from the
116.20 county social services agency, the Office of Ombudsman for Long-Term Care, the Office
116.21 of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that
116.22 provide direct care services to the residents, and facility administration.

116.23 (b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide an
116.24 updated resident census summary document to the county social services agency, the
116.25 Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental
116.26 Disabilities that includes the following information on each resident to be relocated:

116.27 (1) resident name;

116.28 (2) date of birth;

116.29 (3) Social Security number;

116.30 (4) payment source and medical assistance identification number, if applicable;

116.31 (5) county of financial responsibility if the resident is enrolled in a Minnesota health
116.32 care program;

- 117.1 (6) date of admission to the facility;
- 117.2 (7) all current diagnoses;
- 117.3 (8) the name of and contact information for the resident's physician or advanced practice
- 117.4 registered nurse;
- 117.5 (9) the name and contact information for the resident's responsible party;
- 117.6 (10) the name of and contact information for any case manager, managed care coordinator,
- 117.7 or other care coordinator, if known;
- 117.8 (11) information on the resident's status related to commitment and probation; and
- 117.9 (12) the name of the managed care organization in which the resident is enrolled, if
- 117.10 known.

117.11 Sec. 58. Minnesota Statutes 2018, section 144A.161, subdivision 5a, is amended to read:

117.12 Subd. 5a. **Administrator and licensee responsibility to provide notice.** At least 60

117.13 days before the proposed date of closing, reduction, or change in operations as agreed to in

117.14 the plan, the administrator shall send a written notice of closure, reduction, or change in

117.15 operations to each resident being relocated, the resident's responsible party, the resident's

117.16 managed care organization if it is known, the county social services agency, the commissioner

117.17 of health, the commissioner of human services, the Office of Ombudsman for Long-Term

117.18 Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the

117.19 resident's attending physician or advanced practice registered nurse, and, in the case of a

117.20 complete facility closure, the Centers for Medicare and Medicaid Services regional office

117.21 designated representative. The notice must include the following:

- 117.22 (1) the date of the proposed closure, reduction, or change in operations;
- 117.23 (2) the contact information of the individual or individuals in the facility responsible for
- 117.24 providing assistance and information;
- 117.25 (3) notification of upcoming meetings for residents, responsible parties, and resident
- 117.26 and family councils to discuss the plan for relocation of residents;
- 117.27 (4) the contact information of the county social services agency contact person; and
- 117.28 (5) the contact information of the Office of Ombudsman for Long-Term Care and the
- 117.29 Office of Ombudsman for Mental Health and Developmental Disabilities.

118.1 Sec. 59. Minnesota Statutes 2018, section 144A.161, subdivision 5e, is amended to read:

118.2 Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents
118.3 desiring to make site visits to facilities with available beds or other appropriate living options
118.4 to which the resident may relocate, unless it is medically inadvisable, as documented by
118.5 the attending physician or advanced practice registered nurse in the resident's care record.
118.6 The licensee shall make available to the resident at no charge transportation for up to three
118.7 site visits to facilities or other living options within the county or contiguous counties.

118.8 Sec. 60. Minnesota Statutes 2018, section 144A.161, subdivision 5g, is amended to read:

118.9 Subd. 5g. **Licensee responsibilities for final written discharge notice and records**
118.10 **transfer.** (a) The licensee shall provide the resident, the resident's responsible parties, the
118.11 resident's managed care organization, if known, and the resident's attending physician or
118.12 advanced practice registered nurse with a final written discharge notice prior to the relocation
118.13 of the resident. The notice must:

118.14 (1) be provided prior to the actual relocation; and

118.15 (2) identify the effective date of the anticipated relocation and the destination to which
118.16 the resident is being relocated.

118.17 (b) The licensee shall provide the receiving facility or other health, housing, or care
118.18 entity with complete and accurate resident records including contact information for family
118.19 members, responsible parties, social service or other caseworkers, and managed care
118.20 coordinators. These records must also include all information necessary to provide appropriate
118.21 medical care and social services. This includes, but is not limited to, information on
118.22 preadmission screening, Level I and Level II screening, minimum data set (MDS), all other
118.23 assessments, current resident diagnoses, social, behavioral, and medication information,
118.24 required forms, and discharge summaries.

118.25 (c) For residents with special care needs, the licensee shall consult with the receiving
118.26 facility or other placement entity and provide staff training or other preparation as needed
118.27 to assist in providing for the special needs.

118.28 Sec. 61. Minnesota Statutes 2018, section 144A.75, subdivision 3, is amended to read:

118.29 Subd. 3. **Core services.** "Core services" means physician services, registered nursing
118.30 services, advanced practice registered nurse services, medical social services, and counseling
118.31 services. A hospice must ensure that at least two core services are regularly provided directly
118.32 by hospice employees. A hospice provider may use contracted staff if necessary to

119.1 supplement hospice employees in order to meet the needs of patients during peak patient
119.2 loads or under extraordinary circumstances.

119.3 Sec. 62. Minnesota Statutes 2018, section 144A.75, subdivision 6, is amended to read:

119.4 Subd. 6. **Hospice patient.** "Hospice patient" means an individual whose illness has been
119.5 documented by the individual's attending physician or advanced practice registered nurse
119.6 and hospice medical director, who alone or, when unable, through the individual's family
119.7 has voluntarily consented to and received admission to a hospice provider, and who:

119.8 (1) has been diagnosed as terminally ill, with a probable life expectancy of under one
119.9 year; or

119.10 (2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and
119.11 life-threatening illness contributing to a shortened life expectancy; and is not expected to
119.12 survive to adulthood.

119.13 Sec. 63. Minnesota Statutes 2018, section 144A.752, subdivision 1, is amended to read:

119.14 Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of hospice
119.15 providers according to sections 144A.75 to 144A.755. The rules shall include the following:

119.16 (1) provisions to ensure, to the extent possible, the health, safety, well-being, and
119.17 appropriate treatment of persons who receive hospice care;

119.18 (2) requirements that hospice providers furnish the commissioner with specified
119.19 information necessary to implement sections 144A.75 to 144A.755;

119.20 (3) standards of training of hospice provider personnel;

119.21 (4) standards for medication management, which may vary according to the nature of
119.22 the hospice care provided, the setting in which the hospice care is provided, or the status of
119.23 the patient;

119.24 (5) standards for hospice patient and hospice patient's family evaluation or assessment,
119.25 which may vary according to the nature of the hospice care provided or the status of the
119.26 patient; and

119.27 (6) requirements for the involvement of a patient's physician or advanced practice
119.28 registered nurse; documentation of physicians' or advanced practice registered nurses' orders,
119.29 if required, and the patient's hospice plan of care; and maintenance of accurate, current
119.30 clinical records.

120.1 Sec. 64. Minnesota Statutes 2018, section 145.853, subdivision 5, is amended to read:

120.2 Subd. 5. **Notification; medical care.** A law enforcement officer who determines or has
120.3 reason to believe that a disabled person is suffering from an illness causing the person's
120.4 condition shall promptly notify the person's physician or advanced practice registered nurse,
120.5 if practicable. If the officer is unable to ascertain the physician's or advanced practice
120.6 registered nurse's identity or to communicate with the physician or advanced practice
120.7 registered nurse, the officer shall make a reasonable effort to cause the disabled person to
120.8 be transported immediately to a medical practitioner or to a facility where medical treatment
120.9 is available. If the officer believes it unduly dangerous to move the disabled person, the
120.10 officer shall make a reasonable effort to obtain the assistance of a medical practitioner.

120.11 Sec. 65. Minnesota Statutes 2018, section 145.892, subdivision 3, is amended to read:

120.12 Subd. 3. **Pregnant woman.** "Pregnant woman" means an individual determined by a
120.13 licensed physician, advanced practice registered nurse, midwife, or appropriately trained
120.14 registered nurse to have one or more fetuses in utero.

120.15 Sec. 66. Minnesota Statutes 2018, section 145.94, subdivision 2, is amended to read:

120.16 Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or
120.17 to the community, information including data made nonpublic by law, relating to the
120.18 hazardous properties and health hazards of hazardous substances released from a workplace
120.19 if the commissioner finds:

120.20 (1) evidence that a person requesting the information may have suffered or is likely to
120.21 suffer illness or injury from exposure to a hazardous substance; or

120.22 (2) evidence of a community health risk and if the commissioner seeks to have the
120.23 employer cease an activity which results in release of a hazardous substance.

120.24 Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage
120.25 according to established standards to prevent unauthorized use or disclosure. If the nonpublic
120.26 data is required for the diagnosis, treatment, or prevention of illness or injury, a personal
120.27 physician or advanced practice registered nurse may be provided with this information if
120.28 the physician or advanced practice registered nurse agrees to preserve the confidentiality
120.29 of the information, except for patient health records subject to sections 144.291 to 144.298.
120.30 After the disclosure of any hazardous substance information relating to a particular
120.31 workplace, the commissioner shall advise the employer of the information disclosed, the
120.32 date of the disclosure, and the person who received the information.

121.1 Sec. 67. Minnesota Statutes 2018, section 145B.13, is amended to read:

121.2 **145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.**

121.3 In reliance on a patient's living will, a decision to administer, withhold, or withdraw
121.4 medical treatment after the patient has been diagnosed by the attending physician or advanced
121.5 practice registered nurse to be in a terminal condition must always be based on reasonable
121.6 medical practice, including:

121.7 (1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human
121.8 dignity and to alleviate pain;

121.9 (2) oral administration of food or water to a patient who accepts it, except for clearly
121.10 documented medical reasons; and

121.11 (3) in the case of a living will of a patient that the attending physician or advanced
121.12 practice registered nurse knows is pregnant, the living will must not be given effect as long
121.13 as it is possible that the fetus could develop to the point of live birth with continued
121.14 application of life-sustaining treatment.

121.15 Sec. 68. Minnesota Statutes 2018, section 145C.02, is amended to read:

121.16 **145C.02 HEALTH CARE DIRECTIVE.**

121.17 A principal with the capacity to do so may execute a health care directive. A health care
121.18 directive may include one or more health care instructions to direct health care providers,
121.19 others assisting with health care, family members, and a health care agent. A health care
121.20 directive may include a health care power of attorney to appoint a health care agent to make
121.21 health care decisions for the principal when the principal, in the judgment of the principal's
121.22 attending physician or advanced practice registered nurse, lacks decision-making capacity,
121.23 unless otherwise specified in the health care directive.

121.24 Sec. 69. Minnesota Statutes 2019 Supplement, section 145C.05, subdivision 2, is amended
121.25 to read:

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

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

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

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

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

122.10 (5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter
122.11 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

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

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

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

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

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

122.24 (11) health care instructions regarding artificially administered nutrition or hydration;
122.25 and

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

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

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

123.5 (2) a principal who in good faith does not generally select a physician, advanced practice
123.6 registered nurse, or a health care facility for the principal's health care needs may include
123.7 a statement appointing an individual who may determine the principal's decision-making
123.8 capacity, provided that if the need to determine the principal's capacity arises when the
123.9 principal is receiving care under the direction of an attending physician or advanced practice
123.10 registered nurse in a health care facility, the determination must be made by an attending
123.11 physician or advanced practice registered nurse after consultation with the appointed
123.12 individual.

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

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

123.19 Sec. 70. Minnesota Statutes 2018, section 145C.06, is amended to read:

123.20 **145C.06 WHEN EFFECTIVE.**

123.21 A health care directive is effective for a health care decision when:

123.22 (1) it meets the requirements of section 145C.03, subdivision 1; and

123.23 (2) the principal, in the determination of the attending physician or advanced practice
123.24 registered nurse of the principal, lacks decision-making capacity to make the health care
123.25 decision; or if other conditions for effectiveness otherwise specified by the principal have
123.26 been met.

123.27 A health care directive is not effective for a health care decision when the principal, in
123.28 the determination of the attending physician or advanced practice registered nurse of the
123.29 principal, recovers decision-making capacity; or if other conditions for effectiveness
123.30 otherwise specified by the principal have been met.

124.1 Sec. 71. Minnesota Statutes 2018, section 145C.07, subdivision 1, is amended to read:

124.2 Subdivision 1. **Authority.** The health care agent has authority to make any particular
124.3 health care decision only if the principal lacks decision-making capacity, in the determination
124.4 of the attending physician or advanced practice registered nurse, to make or communicate
124.5 that health care decision; or if other conditions for effectiveness otherwise specified by the
124.6 principal have been met. The physician, advanced practice registered nurse, or other health
124.7 care provider shall continue to obtain the principal's informed consent to all health care
124.8 decisions for which the principal has decision-making capacity, unless other conditions for
124.9 effectiveness otherwise specified by the principal have been met. An alternate health care
124.10 agent has authority to act if the primary health care agent is not reasonably available to act.

124.11 Sec. 72. Minnesota Statutes 2018, section 145C.16, is amended to read:

124.12 **145C.16 SUGGESTED FORM.**

124.13 The following is a suggested form of a health care directive and is not a required form.

124.14 HEALTH CARE DIRECTIVE

124.15 I,, understand this document allows me to do ONE OR BOTH of the
124.16 following:

124.17 PART I: Name another person (called the health care agent) to make health care decisions
124.18 for me if I am unable to decide or speak for myself. My health care agent must make health
124.19 care decisions for me based on the instructions I provide in this document (Part II), if any,
124.20 the wishes I have made known to him or her, or must act in my best interest if I have not
124.21 made my health care wishes known.

124.22 AND/OR

124.23 PART II: Give health care instructions to guide others making health care decisions for
124.24 me. If I have named a health care agent, these instructions are to be used by the agent. These
124.25 instructions may also be used by my health care providers, others assisting with my health
124.26 care and my family, in the event I cannot make decisions for myself.

124.27 PART I: APPOINTMENT OF HEALTH CARE AGENT

124.28 THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
124.29 FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

124.30 (I know I can change my agent or alternate agent at any time and I know I do not have
124.31 to appoint an agent or an alternate agent)

125.1 NOTE: If you appoint an agent, you should discuss this health care directive with your agent
 125.2 and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I
 125.3 blank and go to Part II.

125.4 When I am unable to decide or speak for myself, I trust and appoint to
 125.5 make health care decisions for me. This person is called my health care agent.

125.6 Relationship of my health care agent to me:.....

125.7 Telephone number of my health care agent:.....

125.8 Address of my health care agent:.....

125.9 (OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my
 125.10 health care agent is not reasonably available, I trust and appoint to be my health
 125.11 care agent instead.

125.12 Relationship of my alternate health care agent to me:.....

125.13 Telephone number of my alternate health care agent:.....

125.14 Address of my alternate health care agent:.....

125.15 THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO
 125.16 DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF
 125.17 (I know I can change these choices)

125.18 My health care agent is automatically given the powers listed below in (A) through (D).
 125.19 My health care agent must follow my health care instructions in this document or any other
 125.20 instructions I have given to my agent. If I have not given health care instructions, then my
 125.21 agent must act in my best interest.

125.22 Whenever I am unable to decide or speak for myself, my health care agent has the power
 125.23 to:

125.24 (A) Make any health care decision for me. This includes the power to give, refuse, or
 125.25 withdraw consent to any care, treatment, service, or procedures. This includes deciding
 125.26 whether to stop or not start health care that is keeping me or might keep me alive, and
 125.27 deciding about intrusive mental health treatment.

125.28 (B) Choose my health care providers.

125.29 (C) Choose where I live and receive care and support when those choices relate to my
 125.30 health care needs.

126.1 (D) Review my medical records and have the same rights that I would have to give my
126.2 medical records to other people.

126.3 If I DO NOT want my health care agent to have a power listed above in (A) through (D)
126.4 OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

126.5
126.6
126.7

126.8 My health care agent is NOT automatically given the powers listed below in (1) and (2).
126.9 If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in
126.10 front of the power; then my agent WILL HAVE that power.

126.11 (1) To decide whether to donate any parts of my body, including organs, tissues,
126.12 and eyes, when I die.

126.13 (2) To decide what will happen with my body when I die (burial, cremation).

126.14 If I want to say anything more about my health care agent's powers or limits on the
126.15 powers, I can say it here:

126.16
126.17
126.18

126.19 PART II: HEALTH CARE INSTRUCTIONS

126.20 NOTE: Complete this Part II if you wish to give health care instructions. If you appointed
126.21 an agent in Part I, completing this Part II is optional but would be very helpful to your agent.
126.22 However, if you chose not to appoint an agent in Part I, you MUST complete some or all
126.23 of this Part II if you wish to make a valid health care directive.

126.24 These are instructions for my health care when I am unable to decide or speak for myself.
126.25 These instructions must be followed (so long as they address my needs).

126.26 THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

126.27 (I know I can change these choices or leave any of them blank)

126.28 I want you to know these things about me to help you make decisions about my health
126.29 care:

126.30 My goals for my health care:.....
126.31

127.1

127.2 My fears about my health care:.....

127.3

127.4

127.5 My spiritual or religious beliefs and traditions:.....

127.6

127.7

127.8 My beliefs about when life would be no longer worth living:.....

127.9

127.10

127.11 My thoughts about how my medical condition might affect my family:

127.12

127.13

127.14 THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

127.15 (I know I can change these choices or leave any of them blank)

127.16 Many medical treatments may be used to try to improve my medical condition or to

127.17 prolong my life. Examples include artificial breathing by a machine connected to a tube in

127.18 the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries,

127.19 dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a

127.20 while and then stopped if they do not help.

127.21 I have these views about my health care in these situations:

127.22 (Note: You can discuss general feelings, specific treatments, or leave any of them blank)

127.23 If I had a reasonable chance of recovery, and were temporarily unable to decide or speak

127.24 for myself, I would want:.....

127.25

127.26

127.27 If I were dying and unable to decide or speak for myself, I would want:.....

127.28

128.1

128.2 If I were permanently unconscious and unable to decide or speak for myself, I would

128.3 want:.....

128.4

128.5

128.6 If I were completely dependent on others for my care and unable to decide or speak for

128.7 myself, I would want:.....

128.8

128.9

128.10 In all circumstances, my doctors or advanced practice registered nurses will try to keep

128.11 me comfortable and reduce my pain. This is how I feel about pain relief if it would affect

128.12 my alertness or if it could shorten my life:.....

128.13

128.14

128.15 There are other things that I want or do not want for my health care, if possible:

128.16 Who I would like to be my doctor or advanced practice registered nurse:.....

128.17

128.18

128.19 Where I would like to live to receive health care:.....

128.20

128.21

128.22 Where I would like to die and other wishes I have about dying:.....

128.23

128.24

128.25 My wishes about donating parts of my body when I die:.....

128.26

128.27

128.28 My wishes about what happens to my body when I die (cremation, burial):.....

129.1

129.2

129.3 Any other things:.....

129.4

129.5

129.6 PART III: MAKING THE DOCUMENT LEGAL

129.7 This document must be signed by me. It also must either be verified by a notary public
129.8 (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified
129.9 or witnessed.

129.10 I am thinking clearly, I agree with everything that is written in this document, and I have
129.11 made this document willingly.

129.12

129.13 My Signature

129.14 Date signed:

129.15 Date of birth:

129.16 Address:

129.17

129.18 If I cannot sign my name, I can ask someone to sign this document for me.

129.19

129.20 Signature of the person who I asked to sign this document for me.

129.21

129.22 Printed name of the person who I asked to sign this document for me.

129.23 Option 1: Notary Public

129.24 In my presence on (date), (name) acknowledged his/her
129.25 signature on this document or acknowledged that he/she authorized the person signing this
129.26 document to sign on his/her behalf. I am not named as a health care agent or alternate health
129.27 care agent in this document.

129.28

129.29 (Signature of Notary)

(Notary Stamp)

129.30 Option 2: Two Witnesses

130.1 Two witnesses must sign. Only one of the two witnesses can be a health care provider
130.2 or an employee of a health care provider giving direct care to me on the day I sign this
130.3 document.

130.4 Witness One:

130.5 (i) In my presence on (date), (name) acknowledged his/her signature
130.6 on this document or acknowledged that he/she authorized the person signing this document
130.7 to sign on his/her behalf.

130.8 (ii) I am at least 18 years of age.

130.9 (iii) I am not named as a health care agent or an alternate health care agent in this
130.10 document.

130.11 (iv) If I am a health care provider or an employee of a health care provider giving direct
130.12 care to the person listed above in (A), I must initial this box: []

130.13 I certify that the information in (i) through (iv) is true and correct.

130.14

130.15 (Signature of Witness One)

130.16 Address:

130.17

130.18 Witness Two:

130.19 (i) In my presence on (date), (name) acknowledged his/her signature
130.20 on this document or acknowledged that he/she authorized the person signing this document
130.21 to sign on his/her behalf.

130.22 (ii) I am at least 18 years of age.

130.23 (iii) I am not named as a health care agent or an alternate health care agent in this
130.24 document.

130.25 (iv) If I am a health care provider or an employee of a health care provider giving direct
130.26 care to the person listed above in (A), I must initial this box: []

130.27 I certify that the information in (i) through (iv) is true and correct.

130.28

130.29 (Signature of Witness Two)

130.30 Address:

130.31

131.1 REMINDER: Keep this document with your personal papers in a safe place (not in a safe
131.2 deposit box). Give signed copies to your doctors or advanced practice registered nurses,
131.3 family, close friends, health care agent, and alternate health care agent. Make sure your
131.4 doctor or advanced practice registered nurse is willing to follow your wishes. This document
131.5 should be part of your medical record at your physician's or advanced practice registered
131.6 nurse's office and at the hospital, home care agency, hospice, or nursing facility where you
131.7 receive your care.

131.8 Sec. 73. Minnesota Statutes 2018, section 148.6438, subdivision 1, is amended to read:

131.9 Subdivision 1. **Required notification.** In the absence of a physician or advanced practice
131.10 registered nurse referral or prior authorization, and before providing occupational therapy
131.11 services for remuneration or expectation of payment from the client, an occupational therapist
131.12 must provide the following written notification in all capital letters of 12-point or larger
131.13 boldface type, to the client, parent, or guardian:

131.14 "Your health care provider, insurer, or plan may require a physician or advanced practice
131.15 registered nurse referral or prior authorization and you may be obligated for partial or full
131.16 payment for occupational therapy services rendered."

131.17 Information other than this notification may be included as long as the notification
131.18 remains conspicuous on the face of the document. A nonwritten disclosure format may be
131.19 used to satisfy the recipient notification requirement when necessary to accommodate the
131.20 physical condition of a client or client's guardian.

131.21 Sec. 74. Minnesota Statutes 2018, section 151.19, subdivision 4, is amended to read:

131.22 Subd. 4. **Licensing of physicians and advanced practice registered nurses to dispense**
131.23 **drugs; renewals.** (a) The board may grant a license to any physician licensed under chapter
131.24 147 or advanced practice registered nurse licensed under chapter 148 who provides services
131.25 in a health care facility located in a designated health professional shortage area authorizing
131.26 the physician or advanced practice registered nurse to dispense drugs to individuals for
131.27 whom pharmaceutical care is not reasonably available. The license may be renewed annually.
131.28 Any physician or advanced practice registered nurse licensed under this subdivision shall
131.29 be limited to dispensing drugs in a limited service pharmacy and shall be governed by the
131.30 rules adopted by the board when dispensing drugs.

131.31 (b) For the purposes of this subdivision, pharmaceutical care is not reasonably available
131.32 if the limited service pharmacy in which the physician or advanced practice registered nurse

132.1 is dispensing drugs is located in a health professional shortage area, and no other licensed
132.2 pharmacy is located within 15 miles of the limited service pharmacy.

132.3 (c) For the purposes of this subdivision, section 151.15, subdivision 2, shall not apply,
132.4 and section 151.215 shall not apply provided that a physician or advanced practice registered
132.5 nurse granted a license under this subdivision certifies each filled prescription in accordance
132.6 with Minnesota Rules, part 6800.3100, subpart 3.

132.7 (d) Notwithstanding section 151.102, a physician or advanced practice registered nurse
132.8 granted a license under this subdivision may be assisted by a pharmacy technician if the
132.9 technician holds a valid certification from the Pharmacy Technician Certification Board or
132.10 from another national certification body for pharmacy technicians that requires passage of
132.11 a nationally recognized psychometrically valid certification examination for certification
132.12 as determined by the board. The physician or advanced practice registered nurse may
132.13 supervise the pharmacy technician as long as the physician or advanced practice registered
132.14 nurse assumes responsibility for all functions performed by the technician. For purposes of
132.15 this subdivision, supervision does not require the physician or advanced practice registered
132.16 nurse to be physically present if the physician, advanced practice registered nurse, or a
132.17 licensed pharmacist is available, either electronically or by telephone.

132.18 (e) Nothing in this subdivision shall be construed to prohibit a physician or advanced
132.19 practice registered nurse from dispensing drugs pursuant to section 151.37 and Minnesota
132.20 Rules, parts 6800.9950 to 6800.9954.

132.21 Sec. 75. Minnesota Statutes 2018, section 151.21, subdivision 4a, is amended to read:

132.22 Subd. 4a. **Sign.** A pharmacy must post a sign in a conspicuous location and in a typeface
132.23 easily seen at the counter where prescriptions are dispensed stating: "In order to save you
132.24 money, this pharmacy will substitute whenever possible an FDA-approved, less expensive,
132.25 generic drug product, which is therapeutically equivalent to and safely interchangeable with
132.26 the one prescribed by your doctor or advanced practice registered nurse, unless you object
132.27 to this substitution."

132.28 Sec. 76. Minnesota Statutes 2018, section 152.32, subdivision 3, is amended to read:

132.29 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
132.30 lease to and may not otherwise penalize a person solely for the person's status as a patient
132.31 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
132.32 would violate federal law or regulations or cause the school or landlord to lose a monetary
132.33 or licensing-related benefit under federal law or regulations.

133.1 (b) For the purposes of medical care, including organ transplants, a registry program
133.2 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
133.3 equivalent of the authorized use of any other medication used at the discretion of a physician
133.4 or advanced practice registered nurse and does not constitute the use of an illicit substance
133.5 or otherwise disqualify a patient from needed medical care.

133.6 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
133.7 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
133.8 may not discriminate against a person in hiring, termination, or any term or condition of
133.9 employment, or otherwise penalize a person, if the discrimination is based upon either of
133.10 the following:

133.11 (1) the person's status as a patient enrolled in the registry program under sections 152.22
133.12 to 152.37; or

133.13 (2) a patient's positive drug test for cannabis components or metabolites, unless the
133.14 patient used, possessed, or was impaired by medical cannabis on the premises of the place
133.15 of employment or during the hours of employment.

133.16 (d) An employee who is required to undergo employer drug testing pursuant to section
133.17 181.953 may present verification of enrollment in the patient registry as part of the employee's
133.18 explanation under section 181.953, subdivision 6.

133.19 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
133.20 time with a minor child solely based on the person's status as a patient enrolled in the registry
133.21 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
133.22 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
133.23 behavior is such that it creates an unreasonable danger to the safety of the minor as
133.24 established by clear and convincing evidence.

133.25 Sec. 77. Minnesota Statutes 2018, section 245A.143, subdivision 8, is amended to read:

133.26 Subd. 8. **Nutritional services.** (a) The license holder shall ensure that food served is
133.27 nutritious and meets any special dietary needs of the participants as prescribed by the
133.28 participant's physician, advanced practice registered nurse, or dietitian as specified in the
133.29 service delivery plan.

133.30 (b) Food and beverages must be obtained, handled, and properly stored to prevent
133.31 contamination, spoilage, or a threat to the health of a resident.

134.1 Sec. 78. Minnesota Statutes 2018, section 245A.1435, is amended to read:

134.2 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH**
134.3 **IN LICENSED PROGRAMS.**

134.4 (a) When a license holder is placing an infant to sleep, the license holder must place the
134.5 infant on the infant's back, unless the license holder has documentation from the infant's
134.6 physician or advanced practice registered nurse directing an alternative sleeping position
134.7 for the infant. The physician or advanced practice registered nurse directive must be on a
134.8 form approved by the commissioner and must remain on file at the licensed location. An
134.9 infant who independently rolls onto its stomach after being placed to sleep on its back may
134.10 be allowed to remain sleeping on its stomach if the infant is at least six months of age or
134.11 the license holder has a signed statement from the parent indicating that the infant regularly
134.12 rolls over at home.

134.13 (b) The license holder must place the infant in a crib directly on a firm mattress with a
134.14 fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and
134.15 overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of
134.16 the sheet with reasonable effort. The license holder must not place anything in the crib with
134.17 the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title
134.18 16, part 1511. The requirements of this section apply to license holders serving infants
134.19 younger than one year of age. Licensed child care providers must meet the crib requirements
134.20 under section 245A.146. A correction order shall not be issued under this paragraph unless
134.21 there is evidence that a violation occurred when an infant was present in the license holder's
134.22 care.

134.23 (c) If an infant falls asleep before being placed in a crib, the license holder must move
134.24 the infant to a crib as soon as practicable, and must keep the infant within sight of the license
134.25 holder until the infant is placed in a crib. When an infant falls asleep while being held, the
134.26 license holder must consider the supervision needs of other children in care when determining
134.27 how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant
134.28 must not be in a position where the airway may be blocked or with anything covering the
134.29 infant's face.

134.30 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
134.31 for an infant of any age and is prohibited for any infant who has begun to roll over
134.32 independently. However, with the written consent of a parent or guardian according to this
134.33 paragraph, a license holder may place the infant who has not yet begun to roll over on its
134.34 own down to sleep in a one-piece sleeper equipped with an attached system that fastens

135.1 securely only across the upper torso, with no constriction of the hips or legs, to create a
135.2 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
135.3 the license holder must obtain informed written consent for the use of swaddling from the
135.4 parent or guardian of the infant on a form provided by the commissioner and prepared in
135.5 partnership with the Minnesota Sudden Infant Death Center.

135.6 Sec. 79. Minnesota Statutes 2018, section 245C.02, subdivision 18, is amended to read:

135.7 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
135.8 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
135.9 the care of a physician or advanced practice registered nurse whether or not the care of a
135.10 physician or advanced practice registered nurse was sought, or abuse resulting in serious
135.11 injury.

135.12 (b) For purposes of this definition, "care of a physician or advanced practice registered
135.13 nurse" is treatment received or ordered by a physician, physician assistant, advanced practice
135.14 registered nurse, or nurse practitioner, but does not include:

135.15 (1) diagnostic testing, assessment, or observation;

135.16 (2) the application of, recommendation to use, or prescription solely for a remedy that
135.17 is available over the counter without a prescription; or

135.18 (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up
135.19 appointment.

135.20 (c) For purposes of this definition, "abuse resulting in serious injury" means: bruises,
135.21 bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries;
135.22 head injuries with loss of consciousness; extensive second-degree or third-degree burns and
135.23 other burns for which complications are present; extensive second-degree or third-degree
135.24 frostbite and other frostbite for which complications are present; irreversible mobility or
135.25 avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are
135.26 harmful; near drowning; and heat exhaustion or sunstroke.

135.27 (d) Serious maltreatment includes neglect when it results in criminal sexual conduct
135.28 against a child or vulnerable adult.

135.29 Sec. 80. Minnesota Statutes 2018, section 245C.04, subdivision 1, is amended to read:

135.30 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
135.31 shall conduct a background study of an individual required to be studied under section
135.32 245C.03, subdivision 1, at least upon application for initial license for all license types.

136.1 (b) The commissioner shall conduct a background study of an individual required to be
136.2 studied under section 245C.03, subdivision 1, including a child care background study
136.3 subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed
136.4 child care center, certified license-exempt child care center, or legal nonlicensed child care
136.5 provider, on a schedule determined by the commissioner. Except as provided in section
136.6 245C.05, subdivision 5a, a child care background study must include submission of
136.7 fingerprints for a national criminal history record check and a review of the information
136.8 under section 245C.08. A background study for a child care program must be repeated
136.9 within five years from the most recent study conducted under this paragraph.

136.10 (c) At reapplication for a family child care license:

136.11 (1) for a background study affiliated with a licensed family child care center or legal
136.12 nonlicensed child care provider, the individual shall provide information required under
136.13 section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be
136.14 fingerprinted and photographed under section 245C.05, subdivision 5;

136.15 (2) the county agency shall verify the information received under clause (1) and forward
136.16 the information to the commissioner to complete the background study; and

136.17 (3) the background study conducted by the commissioner under this paragraph must
136.18 include a review of the information required under section 245C.08.

136.19 (d) The commissioner is not required to conduct a study of an individual at the time of
136.20 reapplication for a license if the individual's background study was completed by the
136.21 commissioner of human services and the following conditions are met:

136.22 (1) a study of the individual was conducted either at the time of initial licensure or when
136.23 the individual became affiliated with the license holder;

136.24 (2) the individual has been continuously affiliated with the license holder since the last
136.25 study was conducted; and

136.26 (3) the last study of the individual was conducted on or after October 1, 1995.

136.27 (e) The commissioner of human services shall conduct a background study of an
136.28 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),
136.29 who is newly affiliated with a child foster care license holder:

136.30 (1) the county or private agency shall collect and forward to the commissioner the
136.31 information required under section 245C.05, subdivisions 1 and 5, when the child foster
136.32 care applicant or license holder resides in the home where child foster care services are
136.33 provided;

137.1 (2) the child foster care license holder or applicant shall collect and forward to the
137.2 commissioner the information required under section 245C.05, subdivisions 1 and 5, when
137.3 the applicant or license holder does not reside in the home where child foster care services
137.4 are provided; and

137.5 (3) the background study conducted by the commissioner of human services under this
137.6 paragraph must include a review of the information required under section 245C.08,
137.7 subdivisions 1, 3, and 4.

137.8 (f) The commissioner shall conduct a background study of an individual specified under
137.9 section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated
137.10 with an adult foster care or family adult day services and with a family child care license
137.11 holder or a legal nonlicensed child care provider authorized under chapter 119B and:

137.12 (1) except as provided in section 245C.05, subdivision 5a, the county shall collect and
137.13 forward to the commissioner the information required under section 245C.05, subdivision
137.14 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a), (b), and (d), for background
137.15 studies conducted by the commissioner for all family adult day services, for adult foster
137.16 care when the adult foster care license holder resides in the adult foster care residence, and
137.17 for family child care and legal nonlicensed child care authorized under chapter 119B;

137.18 (2) the license holder shall collect and forward to the commissioner the information
137.19 required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs
137.20 (a) and (b), for background studies conducted by the commissioner for adult foster care
137.21 when the license holder does not reside in the adult foster care residence; and

137.22 (3) the background study conducted by the commissioner under this paragraph must
137.23 include a review of the information required under section 245C.08, subdivision 1, paragraph
137.24 (a), and subdivisions 3 and 4.

137.25 (g) Applicants for licensure, license holders, and other entities as provided in this chapter
137.26 must submit completed background study requests to the commissioner using the electronic
137.27 system known as NETStudy before individuals specified in section 245C.03, subdivision
137.28 1, begin positions allowing direct contact in any licensed program.

137.29 (h) For an individual who is not on the entity's active roster, the entity must initiate a
137.30 new background study through NETStudy when:

137.31 (1) an individual returns to a position requiring a background study following an absence
137.32 of 120 or more consecutive days; or

138.1 (2) a program that discontinued providing licensed direct contact services for 120 or
138.2 more consecutive days begins to provide direct contact licensed services again.

138.3 The license holder shall maintain a copy of the notification provided to the commissioner
138.4 under this paragraph in the program's files. If the individual's disqualification was previously
138.5 set aside for the license holder's program and the new background study results in no new
138.6 information that indicates the individual may pose a risk of harm to persons receiving
138.7 services from the license holder, the previous set-aside shall remain in effect.

138.8 (i) For purposes of this section, a physician licensed under chapter 147 or advanced
138.9 practice registered nurse licensed under chapter 148 is considered to be continuously affiliated
138.10 upon the license holder's receipt from the commissioner of health or human services of the
138.11 physician's or advanced practice registered nurse's background study results.

138.12 (j) For purposes of family child care, a substitute caregiver must receive repeat
138.13 background studies at the time of each license renewal.

138.14 (k) A repeat background study at the time of license renewal is not required if the family
138.15 child care substitute caregiver's background study was completed by the commissioner on
138.16 or after October 1, 2017, and the substitute caregiver is on the license holder's active roster
138.17 in NETStudy 2.0.

138.18 (l) Before and after school programs authorized under chapter 119B, are exempt from
138.19 the background study requirements under section 123B.03, for an employee for whom a
138.20 background study under this chapter has been completed.

138.21 Sec. 81. Minnesota Statutes 2018, section 245D.02, subdivision 11, is amended to read:

138.22 Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires
138.23 the program to make a response that is not a part of the program's ordinary provision of
138.24 services to that person, and includes:

138.25 (1) serious injury of a person as determined by section 245.91, subdivision 6;

138.26 (2) a person's death;

138.27 (3) any medical emergency, unexpected serious illness, or significant unexpected change
138.28 in an illness or medical condition of a person that requires the program to call 911, physician
138.29 or advanced practice registered nurse treatment, or hospitalization;

138.30 (4) any mental health crisis that requires the program to call 911, a mental health crisis
138.31 intervention team, or a similar mental health response team or service when available and
138.32 appropriate;

139.1 (5) an act or situation involving a person that requires the program to call 911, law
139.2 enforcement, or the fire department;

139.3 (6) a person's unauthorized or unexplained absence from a program;

139.4 (7) conduct by a person receiving services against another person receiving services
139.5 that:

139.6 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with a
139.7 person's opportunities to participate in or receive service or support;

139.8 (ii) places the person in actual and reasonable fear of harm;

139.9 (iii) places the person in actual and reasonable fear of damage to property of the person;

139.10 or

139.11 (iv) substantially disrupts the orderly operation of the program;

139.12 (8) any sexual activity between persons receiving services involving force or coercion
139.13 as defined under section 609.341, subdivisions 3 and 14;

139.14 (9) any emergency use of manual restraint as identified in section 245D.061 or successor
139.15 provisions; or

139.16 (10) a report of alleged or suspected child or vulnerable adult maltreatment under section
139.17 626.556 or 626.557.

139.18 Sec. 82. Minnesota Statutes 2018, section 245D.11, subdivision 2, is amended to read:

139.19 Subd. 2. **Health and welfare.** The license holder must establish policies and procedures
139.20 that promote health and welfare by ensuring:

139.21 (1) use of universal precautions and sanitary practices in compliance with section
139.22 245D.06, subdivision 2, clause (5);

139.23 (2) if the license holder operates a residential program, health service coordination and
139.24 care according to the requirements in section 245D.05, subdivision 1;

139.25 (3) safe medication assistance and administration according to the requirements in
139.26 sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
139.27 consultation with a registered nurse, ~~nurse practitioner~~ advanced practice registered nurse,
139.28 physician assistant, or medical doctor and require completion of medication administration
139.29 training according to the requirements in section 245D.09, subdivision 4a, paragraph (d).

139.30 Medication assistance and administration includes, but is not limited to:

139.31 (i) providing medication-related services for a person;

- 140.1 (ii) medication setup;
- 140.2 (iii) medication administration;
- 140.3 (iv) medication storage and security;
- 140.4 (v) medication documentation and charting;
- 140.5 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
- 140.6 handling and administration;
- 140.7 (vii) coordination of medication refills;
- 140.8 (viii) handling changes to prescriptions and implementation of those changes;
- 140.9 (ix) communicating with the pharmacy; and
- 140.10 (x) coordination and communication with prescriber;
- 140.11 (4) safe transportation, when the license holder is responsible for transportation of
- 140.12 persons, with provisions for handling emergency situations according to the requirements
- 140.13 in section 245D.06, subdivision 2, clauses (2) to (4);
- 140.14 (5) a plan for ensuring the safety of persons served by the program in emergencies as
- 140.15 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
- 140.16 to the license holder. A license holder with a community residential setting or a day service
- 140.17 facility license must ensure the policy and procedures comply with the requirements in
- 140.18 section 245D.22, subdivision 4;
- 140.19 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11;
- 140.20 and reporting all incidents required to be reported according to section 245D.06, subdivision
- 140.21 1. The plan must:
- 140.22 (i) provide the contact information of a source of emergency medical care and
- 140.23 transportation; and
- 140.24 (ii) require staff to first call 911 when the staff believes a medical emergency may be
- 140.25 life threatening, or to call the mental health crisis intervention team or similar mental health
- 140.26 response team or service when such a team is available and appropriate when the person is
- 140.27 experiencing a mental health crisis; and
- 140.28 (7) a procedure for the review of incidents and emergencies to identify trends or patterns,
- 140.29 and corrective action if needed. The license holder must establish and maintain a
- 140.30 record-keeping system for the incident and emergency reports. Each incident and emergency
- 140.31 report file must contain a written summary of the incident. The license holder must conduct

- 141.1 a review of incident reports for identification of incident patterns, and implementation of
141.2 corrective action as necessary to reduce occurrences. Each incident report must include:
- 141.3 (i) the name of the person or persons involved in the incident. It is not necessary to
141.4 identify all persons affected by or involved in an emergency unless the emergency resulted
141.5 in an incident;
- 141.6 (ii) the date, time, and location of the incident or emergency;
- 141.7 (iii) a description of the incident or emergency;
- 141.8 (iv) a description of the response to the incident or emergency and whether a person's
141.9 coordinated service and support plan addendum or program policies and procedures were
141.10 implemented as applicable;
- 141.11 (v) the name of the staff person or persons who responded to the incident or emergency;
141.12 and
- 141.13 (vi) the determination of whether corrective action is necessary based on the results of
141.14 the review.

141.15 Sec. 83. Minnesota Statutes 2018, section 245D.22, subdivision 7, is amended to read:

141.16 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin-operated
141.17 telephone that is readily accessible. A list of emergency numbers must be posted in a
141.18 prominent location. When an area has a 911 number or a mental health crisis intervention
141.19 team number, both numbers must be posted and the emergency number listed must be 911.
141.20 In areas of the state without a 911 number, the numbers listed must be those of the local
141.21 fire department, police department, emergency transportation, and poison control center.
141.22 The names and telephone numbers of each person's representative, physician or advanced
141.23 practice registered nurse, and dentist must be readily available.

141.24 Sec. 84. Minnesota Statutes 2018, section 245D.25, subdivision 2, is amended to read:

141.25 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed
141.26 by the person's physician, advanced practice registered nurse, or dietitian. Three nutritionally
141.27 balanced meals a day must be served or made available to persons, and nutritious snacks
141.28 must be available between meals.

141.29 Sec. 85. Minnesota Statutes 2018, section 245G.08, subdivision 2, is amended to read:

141.30 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
141.31 obtaining a medical intervention for a client, that are approved in writing by a physician

142.1 who is licensed under chapter 147 or advanced practice registered nurse who is licensed
142.2 under chapter 148, unless:

142.3 (1) the license holder does not provide a service under section 245G.21; and

142.4 (2) a medical intervention is referred to 911, the emergency telephone number, or the
142.5 client's physician or advanced practice registered nurse.

142.6 Sec. 86. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended
142.7 to read:

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

142.15 Sec. 87. Minnesota Statutes 2018, section 245G.08, subdivision 5, is amended to read:

142.16 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
142.17 license holder must meet the requirements in this subdivision if a service provided includes
142.18 the administration of medication.

142.19 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
142.20 licensed practitioner or a registered nurse the task of administration of medication or assisting
142.21 with self-medication, must:

142.22 (1) successfully complete a medication administration training program for unlicensed
142.23 personnel through an accredited Minnesota postsecondary educational institution. A staff
142.24 member's completion of the course must be documented in writing and placed in the staff
142.25 member's personnel file;

142.26 (2) be trained according to a formalized training program that is taught by a registered
142.27 nurse and offered by the license holder. The training must include the process for
142.28 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
142.29 training must be documented in writing and placed in the staff member's personnel records;
142.30 or

143.1 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
143.2 registered nurse must be employed or contracted to develop the policies and procedures for
143.3 administration of medication or assisting with self-administration of medication, or both.

143.4 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
143.5 23. The registered nurse's supervision must include, at a minimum, monthly on-site
143.6 supervision or more often if warranted by a client's health needs. The policies and procedures
143.7 must include:

143.8 (1) a provision that a delegation of administration of medication is limited to the
143.9 administration of a medication that is administered orally, topically, or as a suppository, an
143.10 eye drop, an ear drop, or an inhalant;

143.11 (2) a provision that each client's file must include documentation indicating whether
143.12 staff must conduct the administration of medication or the client must self-administer
143.13 medication, or both;

143.14 (3) a provision that a client may carry emergency medication such as nitroglycerin as
143.15 instructed by the client's physician or advanced practice registered nurse;

143.16 (4) a provision for the client to self-administer medication when a client is scheduled to
143.17 be away from the facility;

143.18 (5) a provision that if a client self-administers medication when the client is present in
143.19 the facility, the client must self-administer medication under the observation of a trained
143.20 staff member;

143.21 (6) a provision that when a license holder serves a client who is a parent with a child,
143.22 the parent may only administer medication to the child under a staff member's supervision;

143.23 (7) requirements for recording the client's use of medication, including staff signatures
143.24 with date and time;

143.25 (8) guidelines for when to inform a nurse of problems with self-administration of
143.26 medication, including a client's failure to administer, refusal of a medication, adverse
143.27 reaction, or error; and

143.28 (9) procedures for acceptance, documentation, and implementation of a prescription,
143.29 whether written, verbal, telephonic, or electronic.

143.30 Sec. 88. Minnesota Statutes 2018, section 245G.21, subdivision 2, is amended to read:

143.31 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
143.32 the license holder. The license holder must set and post a notice of visiting rules and hours,

144.1 including both day and evening times. A client's right to receive visitors other than a personal
144.2 physician or advanced practice registered nurse, religious adviser, county case manager,
144.3 parole or probation officer, or attorney may be subject to visiting hours established by the
144.4 license holder for all clients. The treatment director or designee may impose limitations as
144.5 necessary for the welfare of a client provided the limitation and the reasons for the limitation
144.6 are documented in the client's file. A client must be allowed to receive visits at all reasonable
144.7 times from the client's personal physician or advanced practice registered nurse, religious
144.8 adviser, county case manager, parole or probation officer, and attorney.

144.9 Sec. 89. Minnesota Statutes 2018, section 245G.21, subdivision 3, is amended to read:

144.10 Subd. 3. **Client property management.** A license holder who provides room and board
144.11 and treatment services to a client in the same facility, and any license holder that accepts
144.12 client property must meet the requirements for handling client funds and property in section
144.13 245A.04, subdivision 13. License holders:

144.14 (1) may establish policies regarding the use of personal property to ensure that treatment
144.15 activities and the rights of other clients are not infringed upon;

144.16 (2) may take temporary custody of a client's property for violation of a facility policy;

144.17 (3) must retain the client's property for a minimum of seven days after the client's service
144.18 termination if the client does not reclaim property upon service termination, or for a minimum
144.19 of 30 days if the client does not reclaim property upon service termination and has received
144.20 room and board services from the license holder; and

144.21 (4) must return all property held in trust to the client at service termination regardless
144.22 of the client's service termination status, except that:

144.23 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
144.24 609.5316, must be given to the custody of a local law enforcement agency. If giving the
144.25 property to the custody of a local law enforcement agency violates Code of Federal
144.26 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
144.27 paraphernalia, or drug container must be destroyed by a staff member designated by the
144.28 program director; and

144.29 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
144.30 others must be given to the custody of a local law enforcement agency, and the client must
144.31 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
144.32 and

145.1 (iii) a medication that was determined by a physician or advanced practice registered
145.2 nurse to be harmful after examining the client must be destroyed, except when the client's
145.3 personal physician or advanced practice registered nurse approves the medication for
145.4 continued use.

145.5 Sec. 90. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

145.6 **245H.11 REPORTING.**

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

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

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

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

145.15 Sec. 91. Minnesota Statutes 2018, section 246.711, subdivision 2, is amended to read:

145.16 Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections
145.17 246.71 to 246.722 when all of the following conditions are met:

145.18 (1) a licensed physician or advanced practice registered nurse determines that a significant
145.19 exposure has occurred following the protocol under section 246.721;

145.20 (2) the licensed physician or advanced practice registered nurse for the employee needs
145.21 the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue
145.22 treatment in accordance with the most current guidelines of the United States Public Health
145.23 Service, because of possible exposure to a blood-borne pathogen; and

145.24 (3) the employee consents to providing a blood sample for testing for a blood-borne
145.25 pathogen.

145.26 Sec. 92. Minnesota Statutes 2018, section 246.715, subdivision 2, is amended to read:

145.27 Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but
145.28 does not consent to blood-borne pathogens testing, the secure treatment facility shall ensure
145.29 that the blood is tested for blood-borne pathogens if the employee requests the test, provided
145.30 all of the following criteria are met:

146.1 (1) the employee and secure treatment facility have documented exposure to blood or
146.2 body fluids during performance of the employee's work duties;

146.3 (2) a licensed physician or advanced practice registered nurse has determined that a
146.4 significant exposure has occurred under section 246.711 and has documented that blood-borne
146.5 pathogen test results are needed for beginning, modifying, continuing, or discontinuing
146.6 medical treatment for the employee as recommended by the most current guidelines of the
146.7 United States Public Health Service;

146.8 (3) the employee provides a blood sample for testing for blood-borne pathogens as soon
146.9 as feasible;

146.10 (4) the secure treatment facility asks the patient to consent to a test for blood-borne
146.11 pathogens and the patient does not consent;

146.12 (5) the secure treatment facility has provided the patient and the employee with all of
146.13 the information required by section 246.712; and

146.14 (6) the secure treatment facility has informed the employee of the confidentiality
146.15 requirements of section 246.719 and the penalties for unauthorized release of patient
146.16 information under section 246.72.

146.17 Sec. 93. Minnesota Statutes 2018, section 246.716, subdivision 2, is amended to read:

146.18 Subd. 2. **Procedures without consent.** (a) A secure treatment facility or an employee
146.19 of a secure treatment facility may bring a petition for a court order to require a patient to
146.20 provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in
146.21 the district court in the county where the patient is receiving treatment from the secure
146.22 treatment facility. The secure treatment facility shall serve the petition on the patient three
146.23 days before a hearing on the petition. The petition shall include one or more affidavits
146.24 attesting that:

146.25 (1) the secure treatment facility followed the procedures in sections 246.71 to 246.722
146.26 and attempted to obtain blood-borne pathogen test results according to those sections;

146.27 (2) a licensed physician or advanced practice registered nurse knowledgeable about the
146.28 most current recommendations of the United States Public Health Service has determined
146.29 that a significant exposure has occurred to the employee of a secure treatment facility under
146.30 section 246.721; and

146.31 (3) a physician or advanced practice registered nurse has documented that the employee
146.32 has provided a blood sample and consented to testing for blood-borne pathogens and

147.1 blood-borne pathogen test results are needed for beginning, continuing, modifying, or
147.2 discontinuing medical treatment for the employee under section 246.721.

147.3 (b) Facilities shall cooperate with petitioners in providing any necessary affidavits to
147.4 the extent that facility staff can attest under oath to the facts in the affidavits.

147.5 (c) The court may order the patient to provide a blood sample for blood-borne pathogen
147.6 testing if:

147.7 (1) there is probable cause to believe the employee of a secure treatment facility has
147.8 experienced a significant exposure to the patient;

147.9 (2) the court imposes appropriate safeguards against unauthorized disclosure that must
147.10 specify the persons who have access to the test results and the purposes for which the test
147.11 results may be used;

147.12 (3) a licensed physician or advanced practice registered nurse for the employee of a
147.13 secure treatment facility needs the test results for beginning, continuing, modifying, or
147.14 discontinuing medical treatment for the employee; and

147.15 (4) the court finds a compelling need for the test results. In assessing compelling need,
147.16 the court shall weigh the need for the court-ordered blood collection and test results against
147.17 the interests of the patient, including, but not limited to, privacy, health, safety, or economic
147.18 interests. The court shall also consider whether involuntary blood collection and testing
147.19 would serve the public interests.

147.20 (d) The court shall conduct the proceeding in camera unless the petitioner or the patient
147.21 requests a hearing in open court and the court determines that a public hearing is necessary
147.22 to the public interest and the proper administration of justice.

147.23 (e) The patient may arrange for counsel in any proceeding brought under this subdivision.

147.24 Sec. 94. Minnesota Statutes 2018, section 246.721, is amended to read:

147.25 **246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.**

147.26 (a) A secure treatment facility shall follow applicable Occupational Safety and Health
147.27 Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for
147.28 blood-borne pathogens.

147.29 (b) Every secure treatment facility shall adopt and follow a postexposure protocol for
147.30 employees at a secure treatment facility who have experienced a significant exposure. The
147.31 postexposure protocol must adhere to the most current recommendations of the United
147.32 States Public Health Service and include, at a minimum, the following:

- 148.1 (1) a process for employees to report an exposure in a timely fashion;
- 148.2 (2) a process for an infectious disease specialist, or a licensed physician or advanced
- 148.3 practice registered nurse who is knowledgeable about the most current recommendations
- 148.4 of the United States Public Health Service in consultation with an infectious disease specialist,
- 148.5 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
- 148.6 occurred, and (ii) to provide, under the direction of a licensed physician or advanced practice
- 148.7 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
- 148.8 to the particular blood-borne pathogen or pathogens for which a significant exposure has
- 148.9 been determined;
- 148.10 (3) if there has been a significant exposure, a process to determine whether the patient
- 148.11 has a blood-borne pathogen through disclosure of test results, or through blood collection
- 148.12 and testing as required by sections 246.71 to 246.722;
- 148.13 (4) a process for providing appropriate counseling prior to and following testing for a
- 148.14 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
- 148.15 follow-up recommendations according to the most current recommendations of the United
- 148.16 States Public Health Service, recommendations for testing, and treatment;
- 148.17 (5) a process for providing appropriate counseling under clause (4) to the employee of
- 148.18 a secure treatment facility and to the patient; and
- 148.19 (6) compliance with applicable state and federal laws relating to data practices,
- 148.20 confidentiality, informed consent, and the patient bill of rights.

148.21 Sec. 95. Minnesota Statutes 2018, section 246.722, is amended to read:

148.22 **246.722 IMMUNITY.**

148.23 A secure treatment facility, licensed physician or advanced practice registered nurse,

148.24 and designated health care personnel are immune from liability in any civil, administrative,

148.25 or criminal action relating to the disclosure of test results of a patient to an employee of a

148.26 secure treatment facility and the testing of a blood sample from the patient for blood-borne

148.27 pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

148.28 Sec. 96. Minnesota Statutes 2018, section 251.043, subdivision 1, is amended to read:

148.29 Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in the preceding

148.30 section, the workers' compensation division finds that an employee is suffering from

148.31 tuberculosis contracted in the institution or department by contact with inmates or patients

148.32 therein or by contact with tuberculosis contaminated material therein, it shall order the

149.1 employee to seek the services of a physician, advanced practice registered nurse, or medical
149.2 care facility. There shall be paid to the physician, advanced practice registered nurse, or
149.3 facility where the employee may be received, the same fee for the maintenance and care of
149.4 the person as is received by the institution for the maintenance and care of a nonresident
149.5 patient. If the employee worked in a state hospital or nursing home, payment for the care
149.6 shall be made by the commissioner of human services. If employed in any other institution
149.7 or department the payment shall be made from funds allocated or appropriated for the
149.8 operation of the institution or department. If the employee dies from the effects of the disease
149.9 of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of
149.10 death, the workers' compensation division shall order payment to dependents as provided
149.11 for under the general provisions of the workers' compensation law.

149.12 Sec. 97. Minnesota Statutes 2018, section 252A.02, subdivision 12, is amended to read:

149.13 Subd. 12. **Comprehensive evaluation.** "Comprehensive evaluation" shall consist of:

149.14 (1) a medical report on the health status and physical condition of the proposed ward,
149.15 prepared under the direction of a licensed physician or advanced practice registered nurse;

149.16 (2) a report on the proposed ward's intellectual capacity and functional abilities, specifying
149.17 the tests and other data used in reaching its conclusions, prepared by a psychologist who is
149.18 qualified in the diagnosis of developmental disability; and

149.19 (3) a report from the case manager that includes:

149.20 (i) the most current assessment of individual service needs as described in rules of the
149.21 commissioner;

149.22 (ii) the most current individual service plan under section 256B.092, subdivision 1b;

149.23 and

149.24 (iii) a description of contacts with and responses of near relatives of the proposed ward
149.25 notifying them that a nomination for public guardianship has been made and advising them
149.26 that they may seek private guardianship.

149.27 Each report shall contain recommendations as to the amount of assistance and supervision
149.28 required by the proposed ward to function as independently as possible in society. To be
149.29 considered part of the comprehensive evaluation, reports must be completed no more than
149.30 one year before filing the petition under section 252A.05.

150.1 Sec. 98. Minnesota Statutes 2018, section 252A.04, subdivision 2, is amended to read:

150.2 Subd. 2. **Medication; treatment.** A proposed ward who, at the time the comprehensive
150.3 evaluation is to be performed, has been under medical care shall not be so under the influence
150.4 or so suffer the effects of drugs, medication, or other treatment as to be hampered in the
150.5 testing or evaluation process. When in the opinion of the licensed physician or advanced
150.6 practice registered nurse attending the proposed ward, the discontinuance of medication or
150.7 other treatment is not in the proposed ward's best interest, the physician or advanced practice
150.8 registered nurse shall record a list of all drugs, medication or other treatment which the
150.9 proposed ward received 48 hours immediately prior to any examination, test or interview
150.10 conducted in preparation for the comprehensive evaluation.

150.11 Sec. 99. Minnesota Statutes 2018, section 252A.20, subdivision 1, is amended to read:

150.12 Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01
150.13 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and
150.14 mileage prescribed by law; to each physician, advanced practice registered nurse,
150.15 psychologist, or social worker who assists in the preparation of the comprehensive evaluation
150.16 and who is not in the employ of the local agency or the state Department of Human Services,
150.17 a reasonable sum for services and for travel; and to the ward's counsel, when appointed by
150.18 the court, a reasonable sum for travel and for each day or portion of a day actually employed
150.19 in court or actually consumed in preparing for the hearing. Upon order the county auditor
150.20 shall issue a warrant on the county treasurer for payment of the amount allowed.

150.21 Sec. 100. Minnesota Statutes 2018, section 253B.03, subdivision 4, is amended to read:

150.22 Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a
150.23 personal physician or advanced practice registered nurse, spiritual advisor, and counsel at
150.24 all reasonable times. The patient has the right to continue the practice of religion.

150.25 Sec. 101. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

150.26 Subd. 6d. **Adult mental health treatment.** (a) A competent adult may make a declaration
150.27 of preferences or instructions regarding intrusive mental health treatment. These preferences
150.28 or instructions may include, but are not limited to, consent to or refusal of these treatments.

150.29 (b) A declaration may designate a proxy to make decisions about intrusive mental health
150.30 treatment. A proxy designated to make decisions about intrusive mental health treatments
150.31 and who agrees to serve as proxy may make decisions on behalf of a declarant consistent
150.32 with any desires the declarant expresses in the declaration.

151.1 (c) A declaration is effective only if it is signed by the declarant and two witnesses. The
151.2 witnesses must include a statement that they believe the declarant understands the nature
151.3 and significance of the declaration. A declaration becomes operative when it is delivered
151.4 to the declarant's physician, advanced practice registered nurse, or other mental health
151.5 treatment provider. The physician, advanced practice registered nurse, or provider must
151.6 comply with it to the fullest extent possible, consistent with reasonable medical practice,
151.7 the availability of treatments requested, and applicable law. The physician, advanced practice
151.8 registered nurse, or provider shall continue to obtain the declarant's informed consent to all
151.9 intrusive mental health treatment decisions if the declarant is capable of informed consent.
151.10 A treatment provider may not require a person to make a declaration under this subdivision
151.11 as a condition of receiving services.

151.12 (d) The physician, advanced practice registered nurse, or other provider shall make the
151.13 declaration a part of the declarant's medical record. If the physician, advanced practice
151.14 registered nurse, or other provider is unwilling at any time to comply with the declaration,
151.15 the physician, advanced practice registered nurse, or provider must promptly notify the
151.16 declarant and document the notification in the declarant's medical record. If the declarant
151.17 has been committed as a patient under this chapter, the physician, advanced practice
151.18 registered nurse, or provider may subject a declarant to intrusive treatment in a manner
151.19 contrary to the declarant's expressed wishes, only upon order of the committing court. If
151.20 the declarant is not a committed patient under this chapter, the physician, advanced practice
151.21 registered nurse, or provider may subject the declarant to intrusive treatment in a manner
151.22 contrary to the declarant's expressed wishes, only if the declarant is committed as mentally
151.23 ill or mentally ill and dangerous to the public and a court order authorizing the treatment
151.24 has been issued.

151.25 (e) A declaration under this subdivision may be revoked in whole or in part at any time
151.26 and in any manner by the declarant if the declarant is competent at the time of revocation.
151.27 A revocation is effective when a competent declarant communicates the revocation to the
151.28 attending physician, advanced practice registered nurse, or other provider. The attending
151.29 physician, advanced practice registered nurse, or other provider shall note the revocation
151.30 as part of the declarant's medical record.

151.31 (f) A provider who administers intrusive mental health treatment according to and in
151.32 good faith reliance upon the validity of a declaration under this subdivision is held harmless
151.33 from any liability resulting from a subsequent finding of invalidity.

152.1 (g) In addition to making a declaration under this subdivision, a competent adult may
152.2 delegate parental powers under section 524.5-211 or may nominate a guardian under sections
152.3 524.5-101 to 524.5-502.

152.4 Sec. 102. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

152.5 Subd. 2. **Chemically dependent persons.** Patients hospitalized as chemically dependent
152.6 pursuant to section 253B.04 or 253B.05 shall also be examined within 48 hours of admission.
152.7 At a minimum, the examination shall consist of a physical evaluation by facility staff
152.8 according to procedures established by a physician or advanced practice registered nurse
152.9 and an evaluation by staff knowledgeable and trained in the diagnosis of the alleged disability
152.10 related to the need for admission as a chemically dependent person.

152.11 Sec. 103. Minnesota Statutes 2018, section 253B.23, subdivision 4, is amended to read:

152.12 Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or
152.13 information thought by them to be reliable, who act pursuant to any provision of this chapter
152.14 or who procedurally or physically assist in the commitment of any individual, pursuant to
152.15 this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege
152.16 otherwise existing between patient and physician, patient and advanced practice registered
152.17 nurse, patient and registered nurse, patient and psychologist, patient and examiner, or patient
152.18 and social worker, is waived as to any physician, advanced practice registered nurse,
152.19 registered nurse, psychologist, examiner, or social worker who provides information with
152.20 respect to a patient pursuant to any provision of this chapter.

152.21 Sec. 104. Minnesota Statutes 2018, section 254A.08, subdivision 2, is amended to read:

152.22 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
152.23 program means a social rehabilitation program licensed by the Department of Human
152.24 Services under chapter 245A, and governed by the standards of Minnesota Rules, parts
152.25 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and
152.26 treatment by detoxifying and evaluating the person and providing entrance into a
152.27 comprehensive program. Evaluation of the person shall include verification by a professional,
152.28 after preliminary examination, that the person is intoxicated or has symptoms of substance
152.29 misuse or substance use disorder and appears to be in imminent danger of harming self or
152.30 others. A detoxification program shall have available the services of a licensed physician
152.31 or advanced practice registered nurse for medical emergencies and routine medical
152.32 surveillance. A detoxification program licensed by the Department of Human Services to

153.1 serve both adults and minors at the same site must provide for separate sleeping areas for
153.2 adults and minors.

153.3 Sec. 105. Minnesota Statutes 2018, section 256.9685, subdivision 1a, is amended to read:

153.4 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,
153.5 subdivision 15, the commissioner shall establish an administrative reconsideration process
153.6 for appeals of inpatient hospital services determined to be medically unnecessary. A
153.7 physician, advanced practice registered nurse, or hospital may request a reconsideration of
153.8 the decision that inpatient hospital services are not medically necessary by submitting a
153.9 written request for review to the commissioner within 30 days after receiving notice of the
153.10 decision. The reconsideration process shall take place prior to the procedures of subdivision
153.11 1b and shall be conducted by the medical review agent that is independent of the case under
153.12 reconsideration.

153.13 Sec. 106. Minnesota Statutes 2018, section 256.9685, subdivision 1b, is amended to read:

153.14 Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the
153.15 commissioner may recover inpatient hospital payments for services that have been determined
153.16 to be medically unnecessary after the reconsideration and determinations. A physician,
153.17 advanced practice registered nurse, or hospital may appeal the result of the reconsideration
153.18 process by submitting a written request for review to the commissioner within 30 days after
153.19 receiving notice of the action. The commissioner shall review the medical record and
153.20 information submitted during the reconsideration process and the medical review agent's
153.21 basis for the determination that the services were not medically necessary for inpatient
153.22 hospital services. The commissioner shall issue an order upholding or reversing the decision
153.23 of the reconsideration process based on the review.

153.24 Sec. 107. Minnesota Statutes 2018, section 256.9685, subdivision 1c, is amended to read:

153.25 Subd. 1c. **Judicial review.** A hospital or, physician, or advanced practice registered
153.26 nurse aggrieved by an order of the commissioner under subdivision 1b may appeal the order
153.27 to the district court of the county in which the physician, advanced practice registered nurse,
153.28 or hospital is located by:

153.29 (1) serving a written copy of a notice of appeal upon the commissioner within 30 days
153.30 after the date the commissioner issued the order; and

153.31 (2) filing the original notice of appeal and proof of service with the court administrator
153.32 of the district court. The appeal shall be treated as a dispositive motion under the Minnesota

154.1 General Rules of Practice, rule 115. The district court scope of review shall be as set forth
154.2 in section 14.69.

154.3 Sec. 108. Minnesota Statutes 2018, section 256.975, subdivision 7a, is amended to read:

154.4 Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a)
154.5 All individuals seeking admission to Medicaid-certified nursing facilities, including certified
154.6 boarding care facilities, must be screened prior to admission regardless of income, assets,
154.7 or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs
154.8 (a) and (b). The purpose of the screening is to determine the need for nursing facility level
154.9 of care as described in section 256B.0911, subdivision 4e, and to complete activities required
154.10 under federal law related to mental illness and developmental disability as outlined in
154.11 paragraph (b).

154.12 (b) A person who has a diagnosis or possible diagnosis of mental illness or developmental
154.13 disability must receive a preadmission screening before admission regardless of the
154.14 exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further
154.15 evaluation and specialized services, unless the admission prior to screening is authorized
154.16 by the local mental health authority or the local developmental disabilities case manager,
154.17 or unless authorized by the county agency according to Public Law 101-508.

154.18 (c) The following criteria apply to the preadmission screening:

154.19 (1) requests for preadmission screenings must be submitted via an online form developed
154.20 by the commissioner;

154.21 (2) the Senior LinkAge Line must use forms and criteria developed by the commissioner
154.22 to identify persons who require referral for further evaluation and determination of the need
154.23 for specialized services; and

154.24 (3) the evaluation and determination of the need for specialized services must be done
154.25 by:

154.26 (i) a qualified independent mental health professional, for persons with a primary or
154.27 secondary diagnosis of a serious mental illness; or

154.28 (ii) a qualified developmental disability professional, for persons with a primary or
154.29 secondary diagnosis of developmental disability. For purposes of this requirement, a qualified
154.30 developmental disability professional must meet the standards for a qualified developmental
154.31 disability professional under Code of Federal Regulations, title 42, section 483.430.

155.1 (d) The local county mental health authority or the state developmental disability authority
155.2 under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the
155.3 individual does not meet the nursing facility level of care criteria or needs specialized
155.4 services as defined in Public Laws 100-203 and 101-508. For purposes of this section,
155.5 "specialized services" for a person with developmental disability means active treatment as
155.6 that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

155.7 (e) In assessing a person's needs, the screener shall:

155.8 (1) use an automated system designated by the commissioner;

155.9 (2) consult with care transitions coordinators ~~or~~, physician, or advanced practice registered
155.10 nurse; and

155.11 (3) consider the assessment of the individual's physician or advanced practice registered
155.12 nurse.

155.13 Other personnel may be included in the level of care determination as deemed necessary
155.14 by the screener.

155.15 Sec. 109. Minnesota Statutes 2018, section 256.975, subdivision 11, is amended to read:

155.16 Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging
155.17 shall award competitive grants to eligible applicants for regional and local projects and
155.18 initiatives targeted to a designated community, which may consist of a specific geographic
155.19 area or population, to increase awareness of Alzheimer's disease and other dementias,
155.20 increase the rate of cognitive testing in the population at risk for dementias, promote the
155.21 benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to
155.22 education and resources.

155.23 (b) The project areas for grants include:

155.24 (1) local or community-based initiatives to promote the benefits of physician or advanced
155.25 practice registered nurse consultations for all individuals who suspect a memory or cognitive
155.26 problem;

155.27 (2) local or community-based initiatives to promote the benefits of early diagnosis of
155.28 Alzheimer's disease and other dementias; and

155.29 (3) local or community-based initiatives to provide informational materials and other
155.30 resources to caregivers of persons with dementia.

156.1 (c) Eligible applicants for local and regional grants may include, but are not limited to,
156.2 community health boards, school districts, colleges and universities, community clinics,
156.3 tribal communities, nonprofit organizations, and other health care organizations.

156.4 (d) Applicants must:

156.5 (1) describe the proposed initiative, including the targeted community and how the
156.6 initiative meets the requirements of this subdivision; and

156.7 (2) identify the proposed outcomes of the initiative and the evaluation process to be used
156.8 to measure these outcomes.

156.9 (e) In awarding the regional and local dementia grants, the Minnesota Board on Aging
156.10 must give priority to applicants who demonstrate that the proposed project:

156.11 (1) is supported by and appropriately targeted to the community the applicant serves;

156.12 (2) is designed to coordinate with other community activities related to other health
156.13 initiatives, particularly those initiatives targeted at the elderly;

156.14 (3) is conducted by an applicant able to demonstrate expertise in the project areas;

156.15 (4) utilizes and enhances existing activities and resources or involves innovative
156.16 approaches to achieve success in the project areas; and

156.17 (5) strengthens community relationships and partnerships in order to achieve the project
156.18 areas.

156.19 (f) The board shall divide the state into specific geographic regions and allocate a
156.20 percentage of the money available for the local and regional dementia grants to projects or
156.21 initiatives aimed at each geographic region.

156.22 (g) The board shall award any available grants by January 1, 2016, and each July 1
156.23 thereafter.

156.24 (h) Each grant recipient shall report to the board on the progress of the initiative at least
156.25 once during the grant period, and within two months of the end of the grant period shall
156.26 submit a final report to the board that includes the outcome results.

156.27 (i) The Minnesota Board on Aging shall:

156.28 (1) develop the criteria and procedures to allocate the grants under this subdivision,
156.29 evaluate all applicants on a competitive basis and award the grants, and select qualified
156.30 providers to offer technical assistance to grant applicants and grantees. The selected provider

157.1 shall provide applicants and grantees assistance with project design, evaluation methods,
157.2 materials, and training; and

157.3 (2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on
157.4 the dementia grants programs under this subdivision to the chairs and ranking minority
157.5 members of the senate and house of representatives committees and divisions with jurisdiction
157.6 over health finance and policy. The report shall include:

157.7 (i) information on each grant recipient;

157.8 (ii) a summary of all projects or initiatives undertaken with each grant;

157.9 (iii) the measurable outcomes established by each grantee, an explanation of the
157.10 evaluation process used to determine whether the outcomes were met, and the results of the
157.11 evaluation; and

157.12 (iv) an accounting of how the grant funds were spent.

157.13 Sec. 110. Minnesota Statutes 2018, section 256B.04, subdivision 14a, is amended to read:

157.14 Subd. 14a. **Level of need determination.** Nonemergency medical transportation level
157.15 of need determinations must be performed by a physician, a registered nurse working under
157.16 direct supervision of a physician, a physician assistant, ~~a nurse practitioner~~ an advanced
157.17 practice registered nurse, a licensed practical nurse, or a discharge planner. Nonemergency
157.18 medical transportation level of need determinations must not be performed more than
157.19 annually on any individual, unless the individual's circumstances have sufficiently changed
157.20 so as to require a new level of need determination. Individuals residing in licensed nursing
157.21 facilities are exempt from a level of need determination and are eligible for special
157.22 transportation services until the individual no longer resides in a licensed nursing facility.
157.23 If a person authorized by this subdivision to perform a level of need determination determines
157.24 that an individual requires stretcher transportation, the individual is presumed to maintain
157.25 that level of need until otherwise determined by a person authorized to perform a level of
157.26 need determination, or for six months, whichever is sooner.

157.27 Sec. 111. Minnesota Statutes 2018, section 256B.043, subdivision 2, is amended to read:

157.28 Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part
157.29 of their ongoing duties, shall consider the adequacy of the current system of community
157.30 health clinics and centers both statewide and in urban areas with significant disparities in
157.31 health status and access to services across racial and ethnic groups, including:

157.32 (1) methods to provide 24-hour availability of care through the clinics and centers;

158.1 (2) methods to expand the availability of care through the clinics and centers;

158.2 (3) the use of grants to expand the number of clinics and centers, the services provided,
158.3 and the availability of care; and

158.4 (4) the extent to which increased use of physician assistants, ~~nurse practitioners~~ advanced
158.5 practice registered nurses, medical residents and interns, and other allied health professionals
158.6 in clinics and centers would increase the availability of services.

158.7 (b) The commissioners shall make departmental modifications and legislative
158.8 recommendations as appropriate on the basis of their considerations under paragraph (a).

158.9 Sec. 112. Minnesota Statutes 2018, section 256B.055, subdivision 12, is amended to read:

158.10 Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if
158.11 the person is under age 19 and qualifies as a disabled individual under United States Code,
158.12 title 42, section 1382c(a), and would be eligible for medical assistance under the state plan
158.13 if residing in a medical institution, and the child requires a level of care provided in a hospital,
158.14 nursing facility, or intermediate care facility for persons with developmental disabilities,
158.15 for whom home care is appropriate, provided that the cost to medical assistance under this
158.16 section is not more than the amount that medical assistance would pay for if the child resides
158.17 in an institution. After the child is determined to be eligible under this section, the
158.18 commissioner shall review the child's disability under United States Code, title 42, section
158.19 1382c(a) and level of care defined under this section no more often than annually and may
158.20 elect, based on the recommendation of health care professionals under contract with the
158.21 state medical review team, to extend the review of disability and level of care up to a
158.22 maximum of four years. The commissioner's decision on the frequency of continuing review
158.23 of disability and level of care is not subject to administrative appeal under section 256.045.
158.24 The county agency shall send a notice of disability review to the enrollee six months prior
158.25 to the date the recertification of disability is due. Nothing in this subdivision shall be
158.26 construed as affecting other redeterminations of medical assistance eligibility under this
158.27 chapter and annual cost-effective reviews under this section.

158.28 (b) For purposes of this subdivision, "hospital" means an institution as defined in section
158.29 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and
158.30 licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child
158.31 requires a level of care provided in a hospital if the child is determined by the commissioner
158.32 to need an extensive array of health services, including mental health services, for an
158.33 undetermined period of time, whose health condition requires frequent monitoring and
158.34 treatment by a health care professional or by a person supervised by a health care

159.1 professional, who would reside in a hospital or require frequent hospitalization if these
159.2 services were not provided, and the daily care needs are more complex than a nursing facility
159.3 level of care.

159.4 A child with serious emotional disturbance requires a level of care provided in a hospital
159.5 if the commissioner determines that the individual requires 24-hour supervision because
159.6 the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent
159.7 or frequent psychosomatic disorders or somatopsychic disorders that may become life
159.8 threatening, recurrent or frequent severe socially unacceptable behavior associated with
159.9 psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic
159.10 developmental problems requiring continuous skilled observation, or severe disabling
159.11 symptoms for which office-centered outpatient treatment is not adequate, and which overall
159.12 severely impact the individual's ability to function.

159.13 (c) For purposes of this subdivision, "nursing facility" means a facility which provides
159.14 nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections
159.15 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is
159.16 in need of special treatments provided or supervised by a licensed nurse; or has unpredictable
159.17 episodes of active disease processes requiring immediate judgment by a licensed nurse. For
159.18 purposes of this subdivision, a child requires the level of care provided in a nursing facility
159.19 if the child is determined by the commissioner to meet the requirements of the preadmission
159.20 screening assessment document under section 256B.0911, adjusted to address age-appropriate
159.21 standards for children age 18 and under.

159.22 (d) For purposes of this subdivision, "intermediate care facility for persons with
159.23 developmental disabilities" or "ICF/DD" means a program licensed to provide services to
159.24 persons with developmental disabilities under section 252.28, and chapter 245A, and a
159.25 physical plant licensed as a supervised living facility under chapter 144, which together are
159.26 certified by the Minnesota Department of Health as meeting the standards in Code of Federal
159.27 Regulations, title 42, part 483, for an intermediate care facility which provides services for
159.28 persons with developmental disabilities who require 24-hour supervision and active treatment
159.29 for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child
159.30 requires a level of care provided in an ICF/DD if the commissioner finds that the child has
159.31 a developmental disability in accordance with section 256B.092, is in need of a 24-hour
159.32 plan of care and active treatment similar to persons with developmental disabilities, and
159.33 there is a reasonable indication that the child will need ICF/DD services.

159.34 (e) For purposes of this subdivision, a person requires the level of care provided in a
159.35 nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental

160.1 health treatment because of specific symptoms or functional impairments associated with
160.2 a serious mental illness or disorder diagnosis, which meet severity criteria for mental health
160.3 established by the commissioner and published in March 1997 as the Minnesota Mental
160.4 Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

160.5 (f) The determination of the level of care needed by the child shall be made by the
160.6 commissioner based on information supplied to the commissioner by the parent or guardian,
160.7 the child's physician or physicians or advanced practice registered nurse or advanced practice
160.8 registered nurses, and other professionals as requested by the commissioner. The
160.9 commissioner shall establish a screening team to conduct the level of care determinations
160.10 according to this subdivision.

160.11 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
160.12 must assess the case to determine whether:

160.13 (1) the child qualifies as a disabled individual under United States Code, title 42, section
160.14 1382c(a), and would be eligible for medical assistance if residing in a medical institution;
160.15 and

160.16 (2) the cost of medical assistance services for the child, if eligible under this subdivision,
160.17 would not be more than the cost to medical assistance if the child resides in a medical
160.18 institution to be determined as follows:

160.19 (i) for a child who requires a level of care provided in an ICF/DD, the cost of care for
160.20 the child in an institution shall be determined using the average payment rate established
160.21 for the regional treatment centers that are certified as ICF's/DD;

160.22 (ii) for a child who requires a level of care provided in an inpatient hospital setting
160.23 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
160.24 Rules, part 9505.3520, items F and G; and

160.25 (iii) for a child who requires a level of care provided in a nursing facility according to
160.26 paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules,
160.27 part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates
160.28 which would be paid for children under age 16. The commissioner may authorize an amount
160.29 up to the amount medical assistance would pay for a child referred to the commissioner by
160.30 the preadmission screening team under section 256B.0911.

161.1 Sec. 113. Minnesota Statutes 2018, section 256B.0622, subdivision 2b, is amended to
161.2 read:

161.3 Subd. 2b. **Continuing stay and discharge criteria for assertive community**

161.4 **treatment.** (a) A client receiving assertive community treatment is eligible to continue
161.5 receiving services if:

161.6 (1) the client has not achieved the desired outcomes of their individual treatment plan;

161.7 (2) the client's level of functioning has not been restored, improved, or sustained over
161.8 the time frame outlined in the individual treatment plan;

161.9 (3) the client continues to be at risk for relapse based on current clinical assessment,
161.10 history, or the tenuous nature of the functional gains; or

161.11 (4) the client is functioning effectively with this service and discharge would otherwise
161.12 be indicated but without continued services the client's functioning would decline; and

161.13 (5) one of the following must also apply:

161.14 (i) the client has achieved current individual treatment plan goals but additional goals
161.15 are indicated as evidenced by documented symptoms;

161.16 (ii) the client is making satisfactory progress toward meeting goals and there is
161.17 documentation that supports that continuation of this service shall be effective in addressing
161.18 the goals outlined in the individual treatment plan;

161.19 (iii) the client is making progress, but the specific interventions in the individual treatment
161.20 plan need to be modified so that greater gains, which are consistent with the client's potential
161.21 level of functioning, are possible; or

161.22 (iv) the client fails to make progress or demonstrates regression in meeting goals through
161.23 the interventions outlined in the individual treatment plan.

161.24 (b) Clients receiving assertive community treatment are eligible to be discharged if they
161.25 meet at least one of the following criteria:

161.26 (1) the client and the ACT team determine that assertive community treatment services
161.27 are no longer needed based on the attainment of goals as identified in the individual treatment
161.28 plan and a less intensive level of care would adequately address current goals;

161.29 (2) the client moves out of the ACT team's service area and the ACT team has facilitated
161.30 the referral to either a new ACT team or other appropriate mental health service and has
161.31 assisted the individual in the transition process;

162.1 (3) the client, or the client's legal guardian when applicable, chooses to withdraw from
162.2 assertive community treatment services and documented attempts by the ACT team to
162.3 re-engage the client with the service have not been successful;

162.4 (4) the client has a demonstrated need for a medical nursing home placement lasting
162.5 more than three months, as determined by a physician or advanced practice registered nurse;

162.6 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
162.7 than three months. However, the ACT team must make provisions for the client to return
162.8 to the ACT team upon their discharge or release from the hospital or jail if the client still
162.9 meets eligibility criteria for assertive community treatment and the team is not at full capacity;

162.10 (6) the ACT team is unable to locate, contact, and engage the client for a period of greater
162.11 than three months after persistent efforts by the ACT team to locate the client; or

162.12 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
162.13 team to engage the client in service planning. The ACT team must develop a transition plan
162.14 to arrange for alternate treatment for clients in this situation who have a history of suicide
162.15 attempts, assault, or forensic involvement.

162.16 (c) For all clients who are discharged from assertive community treatment to another
162.17 service provider within the ACT team's service area there is a three-month transfer period,
162.18 from the date of discharge, during which a client who does not adjust well to the new service,
162.19 may voluntarily return to the ACT team. During this period, the ACT team must maintain
162.20 contact with the client's new service provider.

162.21 Sec. 114. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

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

162.24 (a) "Adult rehabilitative mental health services" means mental health services which are
162.25 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
162.26 competencies, personal and emotional adjustment, independent living, parenting skills, and
162.27 community skills, when these abilities are impaired by the symptoms of mental illness.

162.28 Adult rehabilitative mental health services are also appropriate when provided to enable a
162.29 recipient to retain stability and functioning, if the recipient would be at risk of significant
162.30 functional decompensation or more restrictive service settings without these services.

162.31 (1) Adult rehabilitative mental health services instruct, assist, and support the recipient
162.32 in areas such as: interpersonal communication skills, community resource utilization and
162.33 integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting

163.1 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
163.2 transportation skills, medication education and monitoring, mental illness symptom
163.3 management skills, household management skills, employment-related skills, parenting
163.4 skills, and transition to community living services.

163.5 (2) These services shall be provided to the recipient on a one-to-one basis in the recipient's
163.6 home or another community setting or in groups.

163.7 (b) "Medication education services" means services provided individually or in groups
163.8 which focus on educating the recipient about mental illness and symptoms; the role and
163.9 effects of medications in treating symptoms of mental illness; and the side effects of
163.10 medications. Medication education is coordinated with medication management services
163.11 and does not duplicate it. Medication education services are provided by physicians, advanced
163.12 practice registered nurses, pharmacists, physician assistants, or registered nurses.

163.13 (c) "Transition to community living services" means services which maintain continuity
163.14 of contact between the rehabilitation services provider and the recipient and which facilitate
163.15 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
163.16 9505, board and lodging facility, or nursing home. Transition to community living services
163.17 are not intended to provide other areas of adult rehabilitative mental health services.

163.18 Sec. 115. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to
163.19 read:

163.20 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers
163.21 eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed
163.22 practitioner.

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

163.25 Sec. 116. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is
163.26 amended to read:

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

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

164.3 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
164.4 ingredient" is defined as a substance that is represented for use in a drug and when used in
164.5 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
164.6 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
164.7 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
164.8 excipients which are included in the medical assistance formulary. Medical assistance covers
164.9 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
164.10 when the compounded combination is specifically approved by the commissioner or when
164.11 a commercially available product:

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

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

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

164.17 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
164.18 a licensed practitioner or by a licensed pharmacist who meets standards established by the
164.19 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
164.20 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
164.21 with documented vitamin deficiencies, vitamins for children under the age of seven and
164.22 pregnant or nursing women, and any other over-the-counter drug identified by the
164.23 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
164.24 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
164.25 disorders, and this determination shall not be subject to the requirements of chapter 14. A
164.26 pharmacist may prescribe over-the-counter medications as provided under this paragraph
164.27 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
164.28 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
164.29 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
164.30 and make referrals as needed to other health care professionals.

164.31 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
164.32 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
164.33 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
164.34 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and

165.1 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
165.2 individuals, medical assistance may cover drugs from the drug classes listed in United States
165.3 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
165.4 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
165.5 not be covered.

165.6 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
165.7 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
165.8 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
165.9 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

165.10 Sec. 117. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is
165.11 amended to read:

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

165.16 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
165.17 emergency medical care or transportation costs incurred by eligible persons in obtaining
165.18 emergency or nonemergency medical care when paid directly to an ambulance company,
165.19 nonemergency medical transportation company, or other recognized providers of
165.20 transportation services. Medical transportation must be provided by:

165.21 (1) nonemergency medical transportation providers who meet the requirements of this
165.22 subdivision;

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

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

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

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

165.27 (c) Medical assistance covers nonemergency medical transportation provided by
165.28 nonemergency medical transportation providers enrolled in the Minnesota health care
165.29 programs. All nonemergency medical transportation providers must comply with the
165.30 operating standards for special transportation service as defined in sections 174.29 to 174.30
165.31 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
165.32 commissioner and reported on the claim as the individual who provided the service. All

166.1 nonemergency medical transportation providers shall bill for nonemergency medical
166.2 transportation services in accordance with Minnesota health care programs criteria. Publicly
166.3 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
166.4 requirements outlined in this paragraph.

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

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

166.8 (2) the provider has initiated background studies on the individuals specified in section
166.9 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

166.29 (g) The commissioner may use an order by the recipient's attending physician, advanced
166.30 practice registered nurse, or a medical or mental health professional to certify that the
166.31 recipient requires nonemergency medical transportation services. Nonemergency medical
166.32 transportation providers shall perform driver-assisted services for eligible individuals, when

167.1 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
167.2 residence or place of business, assistance with admittance of the individual to the medical
167.3 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
167.4 or stretchers in the vehicle.

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

167.9 Nonemergency medical transportation providers may not bill for separate base rates for
167.10 the continuation of a trip beyond the original destination. Nonemergency medical
167.11 transportation providers must maintain trip logs, which include pickup and drop-off times,
167.12 signed by the medical provider or client, whichever is deemed most appropriate, attesting
167.13 to mileage traveled to obtain covered medical services. Clients requesting client mileage
167.14 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
167.15 services.

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

167.21 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

168.17 (k) The commissioner shall:

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

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

168.21 (3) investigate all complaints and appeals.

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

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

168.31 (1) \$0.22 per mile for client reimbursement;

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

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

169.6 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

169.7 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

169.8 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

169.9 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
169.10 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

169.28 Sec. 118. Minnesota Statutes 2018, section 256B.0625, subdivision 26, is amended to
169.29 read:

169.30 Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary
169.31 in making a determination for eligibility for individualized education program and

170.1 individualized family service plan services and for medical services identified in a recipient's
170.2 individualized education program and individualized family service plan and covered under
170.3 the medical assistance state plan. Covered services include occupational therapy, physical
170.4 therapy, speech-language therapy, clinical psychological services, nursing services, school
170.5 psychological services, school social work services, personal care assistants serving as
170.6 management aides, assistive technology devices, transportation services, health assessments,
170.7 and other services covered under the medical assistance state plan. Mental health services
170.8 eligible for medical assistance reimbursement must be provided or coordinated through a
170.9 children's mental health collaborative where a collaborative exists if the child is included
170.10 in the collaborative operational target population. The provision or coordination of services
170.11 does not require that the individualized education program be developed by the collaborative.

170.12 The services may be provided by a Minnesota school district that is enrolled as a medical
170.13 assistance provider or its subcontractor, and only if the services meet all the requirements
170.14 otherwise applicable if the service had been provided by a provider other than a school
170.15 district, in the following areas: medical necessity, physician's or advanced practice registered
170.16 nurse's orders, documentation, personnel qualifications, and prior authorization requirements.
170.17 The nonfederal share of costs for services provided under this subdivision is the responsibility
170.18 of the local school district as provided in section 125A.74. Services listed in a child's
170.19 individualized education program are eligible for medical assistance reimbursement only
170.20 if those services meet criteria for federal financial participation under the Medicaid program.

170.21 (b) Approval of health-related services for inclusion in the individualized education
170.22 program does not require prior authorization for purposes of reimbursement under this
170.23 chapter. The commissioner may require physician or advanced practice registered nurse
170.24 review and approval of the plan not more than once annually or upon any modification of
170.25 the individualized education program that reflects a change in health-related services.

170.26 (c) Services of a speech-language pathologist provided under this section are covered
170.27 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

170.28 (1) holds a masters degree in speech-language pathology;

170.29 (2) is licensed by the Professional Educator Licensing and Standards Board as an
170.30 educational speech-language pathologist; and

170.31 (3) either has a certificate of clinical competence from the American Speech and Hearing
170.32 Association, has completed the equivalent educational requirements and work experience
170.33 necessary for the certificate or has completed the academic program and is acquiring
170.34 supervised work experience to qualify for the certificate.

171.1 (d) Medical assistance coverage for medically necessary services provided under other
171.2 subdivisions in this section may not be denied solely on the basis that the same or similar
171.3 services are covered under this subdivision.

171.4 (e) The commissioner shall develop and implement package rates, bundled rates, or per
171.5 diem rates for special education services under which separately covered services are grouped
171.6 together and billed as a unit in order to reduce administrative complexity.

171.7 (f) The commissioner shall develop a cost-based payment structure for payment of these
171.8 services. Only costs reported through the designated Minnesota Department of Education
171.9 data systems in distinct service categories qualify for inclusion in the cost-based payment
171.10 structure. The commissioner shall reimburse claims submitted based on an interim rate, and
171.11 shall settle at a final rate once the department has determined it. The commissioner shall
171.12 notify the school district of the final rate. The school district has 60 days to appeal the final
171.13 rate. To appeal the final rate, the school district shall file a written appeal request to the
171.14 commissioner within 60 days of the date the final rate determination was mailed. The appeal
171.15 request shall specify (1) the disputed items and (2) the name and address of the person to
171.16 contact regarding the appeal.

171.17 (g) Effective July 1, 2000, medical assistance services provided under an individualized
171.18 education program or an individual family service plan by local school districts shall not
171.19 count against medical assistance authorization thresholds for that child.

171.20 (h) Nursing services as defined in section 148.171, subdivision 15, and provided as an
171.21 individualized education program health-related service, are eligible for medical assistance
171.22 payment if they are otherwise a covered service under the medical assistance program.
171.23 Medical assistance covers the administration of prescription medications by a licensed nurse
171.24 who is employed by or under contract with a school district when the administration of
171.25 medications is identified in the child's individualized education program. The simple
171.26 administration of medications alone is not covered under medical assistance when
171.27 administered by a provider other than a school district or when it is not identified in the
171.28 child's individualized education program.

171.29 Sec. 119. Minnesota Statutes 2018, section 256B.0625, subdivision 28, is amended to
171.30 read:

171.31 Subd. 28. ~~Certified nurse practitioner~~ Advanced practice registered nurse
171.32 **services.** Medical assistance covers services performed by a certified pediatric nurse
171.33 ~~practitioner~~ advanced practice registered nurse, a certified family ~~nurse practitioner~~ advanced
171.34 practice registered nurse, a certified adult ~~nurse practitioner~~ advanced practice registered

172.1 nurse, a certified obstetric/gynecological ~~nurse-practitioner~~ advanced practice registered
172.2 nurse, a certified neonatal ~~nurse-practitioner~~ advanced practice registered nurse, or a certified
172.3 geriatric ~~nurse-practitioner~~ advanced practice registered nurse in independent practice, if:
172.4 (1) the service provided on an inpatient basis is not included as part of the cost for
172.5 inpatient services included in the operating payment rate;
172.6 (2) the service is otherwise covered under this chapter as a physician service; and
172.7 (3) the service is within the scope of practice of the ~~nurse-practitioner's~~ advanced practice
172.8 registered nurse's license as a registered nurse, as defined in section 148.171.

172.9 Sec. 120. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is
172.10 amended to read:

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

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

- 172.18 (1) verbal or visual reminders of discharge orders;
- 172.19 (2) recording and reporting of vital signs to the patient's primary care provider;
- 172.20 (3) medication access confirmation;
- 172.21 (4) food access confirmation; and
- 172.22 (5) identification of home hazards.

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

- 172.27 (1) medication access confirmation;
- 172.28 (2) food access confirmation; and
- 172.29 (3) identification of home hazards.

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

173.3 Sec. 121. Minnesota Statutes 2018, section 256B.0654, subdivision 1, is amended to read:

173.4 Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing
173.5 services provided to recipients who meet the criteria for regular home care nursing and
173.6 require life-sustaining interventions to reduce the risk of long-term injury or death.

173.7 (b) "Home care nursing" means ongoing ~~physician-ordered~~ hourly nursing ordered by
173.8 a physician or advanced practice registered nurse and services performed by a registered
173.9 nurse or licensed practical nurse within the scope of practice as defined by the Minnesota
173.10 Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a
173.11 person's health.

173.12 (c) "Home care nursing agency" means a medical assistance enrolled provider licensed
173.13 under chapter 144A to provide home care nursing services.

173.14 (d) "Regular home care nursing" means home care nursing provided because:

173.15 (1) the recipient requires more individual and continuous care than can be provided
173.16 during a skilled nurse visit; or

173.17 (2) the cares are outside of the scope of services that can be provided by a home health
173.18 aide or personal care assistant.

173.19 (e) "Shared home care nursing" means the provision of home care nursing services by
173.20 a home care nurse to two recipients at the same time and in the same setting.

173.21 Sec. 122. Minnesota Statutes 2018, section 256B.0654, subdivision 2a, is amended to
173.22 read:

173.23 Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

173.24 (1) in the recipient's home or outside the home when normal life activities require;

173.25 (2) when the recipient requires more individual and continuous care than can be provided
173.26 during a skilled nurse visit; and

173.27 (3) when the care required is outside of the scope of services that can be provided by a
173.28 home health aide or personal care assistant.

173.29 (b) Home care nursing services must be:

173.30 (1) assessed by a registered nurse on a form approved by the commissioner;

174.1 (2) ordered by a physician or advanced practice registered nurse and documented in a
174.2 plan of care that is reviewed by the physician at least once every 60 days; and
174.3 (3) authorized by the commissioner under section 256B.0652.

174.4 Sec. 123. Minnesota Statutes 2018, section 256B.0654, subdivision 3, is amended to read:

174.5 Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared
174.6 home care nursing services by a home care nurse shall be limited according to this
174.7 subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory
174.8 provisions relating to home care nursing services apply to shared home care nursing services.
174.9 Nothing in this subdivision shall be construed to reduce the total number of home care
174.10 nursing hours authorized for an individual recipient.

174.11 (b) Shared home care nursing is the provision of nursing services by a home care nurse
174.12 to two medical assistance eligible recipients at the same time and in the same setting. This
174.13 subdivision does not apply when a home care nurse is caring for multiple recipients in more
174.14 than one setting.

174.15 (c) For the purposes of this subdivision, "setting" means:

174.16 (1) the home residence or foster care home of one of the individual recipients as defined
174.17 in section 256B.0651;

174.18 (2) a child care program licensed under chapter 245A or operated by a local school
174.19 district or private school;

174.20 (3) an adult day care service licensed under chapter 245A; or

174.21 (4) outside the home residence or foster care home of one of the recipients when normal
174.22 life activities take the recipients outside the home.

174.23 (d) The home care nursing agency must offer the recipient the option of shared or
174.24 one-on-one home care nursing services. The recipient may withdraw from participating in
174.25 a shared service arrangement at any time.

174.26 (e) The recipient or the recipient's legal representative, and the recipient's physician or
174.27 advanced practice registered nurse, in conjunction with the home care nursing agency, shall
174.28 determine:

174.29 (1) whether shared home care nursing care is an appropriate option based on the individual
174.30 needs and preferences of the recipient; and

175.1 (2) the amount of shared home care nursing services authorized as part of the overall
175.2 authorization of nursing services.

175.3 (f) The recipient or the recipient's legal representative, in conjunction with the home
175.4 care nursing agency, shall approve the setting, grouping, and arrangement of shared home
175.5 care nursing care based on the individual needs and preferences of the recipients. Decisions
175.6 on the selection of recipients to share services must be based on the ages of the recipients,
175.7 compatibility, and coordination of their care needs.

175.8 (g) The following items must be considered by the recipient or the recipient's legal
175.9 representative and the home care nursing agency, and documented in the recipient's health
175.10 service record:

175.11 (1) the additional training needed by the home care nurse to provide care to two recipients
175.12 in the same setting and to ensure that the needs of the recipients are met appropriately and
175.13 safely;

175.14 (2) the setting in which the shared home care nursing care will be provided;

175.15 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of
175.16 the service and process used to make changes in service or setting;

175.17 (4) a contingency plan which accounts for absence of the recipient in a shared home
175.18 care nursing setting due to illness or other circumstances;

175.19 (5) staffing backup contingencies in the event of employee illness or absence; and

175.20 (6) arrangements for additional assistance to respond to urgent or emergency care needs
175.21 of the recipients.

175.22 (h) The documentation for shared home care nursing must be on a form approved by
175.23 the commissioner for each individual recipient sharing home care nursing. The documentation
175.24 must be part of the recipient's health service record and include:

175.25 (1) permission by the recipient or the recipient's legal representative for the maximum
175.26 number of shared nursing hours per week chosen by the recipient and permission for shared
175.27 home care nursing services provided in and outside the recipient's home residence;

175.28 (2) revocation by the recipient or the recipient's legal representative for the shared home
175.29 care nursing permission, or services provided to others in and outside the recipient's
175.30 residence; and

175.31 (3) daily documentation of the shared home care nursing services provided by each
175.32 identified home care nurse, including:

- 176.1 (i) the names of each recipient receiving shared home care nursing services;
- 176.2 (ii) the setting for the shared services, including the starting and ending times that the
176.3 recipient received shared home care nursing care; and
- 176.4 (iii) notes by the home care nurse regarding changes in the recipient's condition, problems
176.5 that may arise from the sharing of home care nursing services, and scheduling and care
176.6 issues.
- 176.7 (i) The commissioner shall provide a rate methodology for shared home care nursing.
176.8 For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times
176.9 the regular home care nursing rates paid for serving a single individual by a registered nurse
176.10 or licensed practical nurse. These rates apply only to situations in which both recipients are
176.11 present and receive shared home care nursing care on the date for which the service is billed.
- 176.12 Sec. 124. Minnesota Statutes 2018, section 256B.0654, subdivision 4, is amended to read:
- 176.13 **Subd. 4. Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary
176.14 services that require specialized nursing skills and are provided by parents of minor children,
176.15 family foster parents, spouses, and legal guardians who are providing home care nursing
176.16 care under the following conditions:
- 176.17 (1) the provision of these services is not legally required of the parents, spouses, or legal
176.18 guardians;
- 176.19 (2) the services are necessary to prevent hospitalization of the recipient; and
- 176.20 (3) the recipient is eligible for state plan home care or a home and community-based
176.21 waiver and one of the following hardship criteria are met:
- 176.22 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
176.23 provide nursing care for the recipient;
- 176.24 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
176.25 less compensation to provide nursing care for the recipient;
- 176.26 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide
176.27 nursing care for the recipient; or
- 176.28 (iv) because of labor conditions, special language needs, or intermittent hours of care
176.29 needed, the parent, spouse, or legal guardian is needed in order to provide adequate home
176.30 care nursing services to meet the medical needs of the recipient.

177.1 (b) Home care nursing may be provided by a parent, spouse, family foster parent, or
177.2 legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided
177.3 by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing
177.4 services covered and available under liable third-party payors, including Medicare. The
177.5 home care nursing provided by a parent, spouse, family foster parent, or legal guardian must
177.6 be included in the service agreement. Authorized nursing services for a single recipient or
177.7 recipients with the same residence and provided by the parent, spouse, family foster parent,
177.8 or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight
177.9 hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents,
177.10 spouse, family foster parent, or legal guardian shall not provide more than 40 hours of
177.11 services in a seven-day period. For parents, family foster parents, and legal guardians, 40
177.12 hours is the total amount allowed regardless of the number of children or adults who receive
177.13 services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's
177.14 obligation of assuming the nonreimbursed family responsibilities of emergency backup
177.15 caregiver and primary caregiver.

177.16 (c) A parent, family foster parent, or a spouse may not be paid to provide home care
177.17 nursing care if:

177.18 (1) the parent or spouse fails to pass a criminal background check according to chapter
177.19 245C;

177.20 (2) it has been determined by the home care nursing agency, the case manager, or the
177.21 physician or advanced practice registered nurse that the home care nursing provided by the
177.22 parent, family foster parent, spouse, or legal guardian is unsafe; or

177.23 (3) the parent, family foster parent, spouse, or legal guardian does not follow physician
177.24 or advanced practice registered nurse orders.

177.25 (d) For purposes of this section, "assessment" means a review and evaluation of a
177.26 recipient's need for home care services conducted in person. Assessments for home care
177.27 nursing must be conducted by a registered nurse.

177.28 Sec. 125. Minnesota Statutes 2018, section 256B.0659, subdivision 2, is amended to read:

177.29 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
177.30 assistance services eligible for payment include services and supports furnished to an
177.31 individual, as needed, to assist in:

177.32 (1) activities of daily living;

177.33 (2) health-related procedures and tasks;

- 178.1 (3) observation and redirection of behaviors; and
- 178.2 (4) instrumental activities of daily living.
- 178.3 (b) Activities of daily living include the following covered services:
- 178.4 (1) dressing, including assistance with choosing, application, and changing of clothing
- 178.5 and application of special appliances, wraps, or clothing;
- 178.6 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
- 178.7 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
- 178.8 except for recipients who are diabetic or have poor circulation;
- 178.9 (3) bathing, including assistance with basic personal hygiene and skin care;
- 178.10 (4) eating, including assistance with hand washing and application of orthotics required
- 178.11 for eating, transfers, and feeding;
- 178.12 (5) transfers, including assistance with transferring the recipient from one seating or
- 178.13 reclining area to another;
- 178.14 (6) mobility, including assistance with ambulation, including use of a wheelchair.
- 178.15 Mobility does not include providing transportation for a recipient;
- 178.16 (7) positioning, including assistance with positioning or turning a recipient for necessary
- 178.17 care and comfort; and
- 178.18 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
- 178.19 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
- 178.20 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
- 178.21 clothing.
- 178.22 (c) Health-related procedures and tasks include the following covered services:
- 178.23 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
- 178.24 functioning;
- 178.25 (2) assistance with self-administered medication as defined by this section, including
- 178.26 reminders to take medication, bringing medication to the recipient, and assistance with
- 178.27 opening medication under the direction of the recipient or responsible party, including
- 178.28 medications given through a nebulizer;
- 178.29 (3) interventions for seizure disorders, including monitoring and observation; and
- 178.30 (4) other activities considered within the scope of the personal care service and meeting
- 178.31 the definition of health-related procedures and tasks under this section.

179.1 (d) A personal care assistant may provide health-related procedures and tasks associated
179.2 with the complex health-related needs of a recipient if the procedures and tasks meet the
179.3 definition of health-related procedures and tasks under this section and the personal care
179.4 assistant is trained by a qualified professional and demonstrates competency to safely
179.5 complete the procedures and tasks. Delegation of health-related procedures and tasks and
179.6 all training must be documented in the personal care assistance care plan and the recipient's
179.7 and personal care assistant's files. A personal care assistant must not determine the medication
179.8 dose or time for medication.

179.9 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
179.10 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
179.11 support there must be:

179.12 (1) delegation and training by a registered nurse, advanced practice registered nurse,
179.13 certified or licensed respiratory therapist, or a physician;

179.14 (2) utilization of clean rather than sterile procedure;

179.15 (3) specialized training about the health-related procedures and tasks and equipment,
179.16 including ventilator operation and maintenance;

179.17 (4) individualized training regarding the needs of the recipient; and

179.18 (5) supervision by a qualified professional who is a registered nurse.

179.19 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
179.20 recipient for episodes where there is a need for redirection due to behaviors. Training of
179.21 the personal care assistant must occur based on the needs of the recipient, the personal care
179.22 assistance care plan, and any other support services provided.

179.23 (g) Instrumental activities of daily living under subdivision 1, paragraph (i).

179.24 Sec. 126. Minnesota Statutes 2018, section 256B.0659, subdivision 4, is amended to read:

179.25 **Subd. 4. Assessment for personal care assistance services; limitations.** (a) An
179.26 assessment as defined in subdivision 3a must be completed for personal care assistance
179.27 services.

179.28 (b) The following limitations apply to the assessment:

179.29 (1) a person must be assessed as dependent in an activity of daily living based on the
179.30 person's daily need or need on the days during the week the activity is completed for:

179.31 (i) cuing and constant supervision to complete the task; or

180.1 (ii) hands-on assistance to complete the task; and

180.2 (2) a child may not be found to be dependent in an activity of daily living if because of
180.3 the child's age an adult would either perform the activity for the child or assist the child
180.4 with the activity. Assistance needed is the assistance appropriate for a typical child of the
180.5 same age.

180.6 (c) Assessment for complex health-related needs must meet the criteria in this paragraph.
180.7 A recipient qualifies as having complex health-related needs if the recipient has one or more
180.8 of the interventions that are ordered by a physician or advanced practice registered nurse,
180.9 specified in a personal care assistance care plan or community support plan developed under
180.10 section 256B.0911, and found in the following:

180.11 (1) tube feedings requiring:

180.12 (i) a gastrojejunostomy tube; or

180.13 (ii) continuous tube feeding lasting longer than 12 hours per day;

180.14 (2) wounds described as:

180.15 (i) stage III or stage IV;

180.16 (ii) multiple wounds;

180.17 (iii) requiring sterile or clean dressing changes or a wound vac; or

180.18 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
180.19 care;

180.20 (3) parenteral therapy described as:

180.21 (i) IV therapy more than two times per week lasting longer than four hours for each
180.22 treatment; or

180.23 (ii) total parenteral nutrition (TPN) daily;

180.24 (4) respiratory interventions, including:

180.25 (i) oxygen required more than eight hours per day;

180.26 (ii) respiratory vest more than one time per day;

180.27 (iii) bronchial drainage treatments more than two times per day;

180.28 (iv) sterile or clean suctioning more than six times per day;

180.29 (v) dependence on another to apply respiratory ventilation augmentation devices such
180.30 as BiPAP and CPAP; and

- 181.1 (vi) ventilator dependence under section 256B.0652;
- 181.2 (5) insertion and maintenance of catheter, including:
- 181.3 (i) sterile catheter changes more than one time per month;
- 181.4 (ii) clean intermittent catheterization, and including self-catheterization more than six
- 181.5 times per day; or
- 181.6 (iii) bladder irrigations;
- 181.7 (6) bowel program more than two times per week requiring more than 30 minutes to
- 181.8 perform each time;
- 181.9 (7) neurological intervention, including:
- 181.10 (i) seizures more than two times per week and requiring significant physical assistance
- 181.11 to maintain safety; or
- 181.12 (ii) swallowing disorders diagnosed by a physician or advanced practice registered nurse
- 181.13 and requiring specialized assistance from another on a daily basis; and
- 181.14 (8) other congenital or acquired diseases creating a need for significantly increased direct
- 181.15 hands-on assistance and interventions in six to eight activities of daily living.
- 181.16 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
- 181.17 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
- 181.18 assistance at least four times per week and shows one or more of the following behaviors:
- 181.19 (1) physical aggression towards self or others, or destruction of property that requires
- 181.20 the immediate response of another person;
- 181.21 (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
- 181.22 or
- 181.23 (3) increased need for assistance for recipients who are verbally aggressive or resistive
- 181.24 to care so that the time needed to perform activities of daily living is increased.
- 181.25 Sec. 127. Minnesota Statutes 2018, section 256B.0659, subdivision 8, is amended to read:
- 181.26 Subd. 8. **Communication with recipient's physician or advanced practice registered**
- 181.27 **nurse**. The personal care assistance program requires communication with the recipient's
- 181.28 physician or advanced practice registered nurse about a recipient's assessed needs for personal
- 181.29 care assistance services. The commissioner shall work with the state medical director to
- 181.30 develop options for communication with the recipient's physician or advanced practice
- 181.31 registered nurse.

182.1 Sec. 128. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is
182.2 amended to read:

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

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

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

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

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

182.11 (3) enroll with the department as a personal care assistant after clearing a background
182.12 study. Except as provided in subdivision 11a, before a personal care assistant provides
182.13 services, the personal care assistance provider agency must initiate a background study on
182.14 the personal care assistant under chapter 245C, and the personal care assistance provider
182.15 agency must have received a notice from the commissioner that the personal care assistant
182.16 is:

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

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

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

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

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

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

182.29 (8) effective January 1, 2010, complete standardized training as determined by the
182.30 commissioner before completing enrollment. The training must be available in languages
182.31 other than English and to those who need accommodations due to disabilities. Personal care
182.32 assistant training must include successful completion of the following training components:

183.1 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
183.2 roles and responsibilities of personal care assistants including information about assistance
183.3 with lifting and transfers for recipients, emergency preparedness, orientation to positive
183.4 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
183.5 training components, the personal care assistant must demonstrate the competency to provide
183.6 assistance to recipients;

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

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

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

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

183.18 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
183.19 17a if the personal care assistant providing the services:

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

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

183.26 Sec. 129. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is
183.27 amended to read:

183.28 Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The
183.29 case manager shall implement the coordinated service and support plan for each alternative
183.30 care client and ensure that a client's service needs and eligibility are reassessed at least every
183.31 12 months. The coordinated service and support plan must meet the requirements in section
183.32 256S.10. The plan shall include any services prescribed by the individual's attending
183.33 physician or advanced practice registered nurse as necessary to allow the individual to

184.1 remain in a community setting. In developing the individual's care plan, the case manager
184.2 should include the use of volunteers from families and neighbors, religious organizations,
184.3 social clubs, and civic and service organizations to support the formal home care services.
184.4 The lead agency shall be held harmless for damages or injuries sustained through the use
184.5 of volunteers under this subdivision including workers' compensation liability. The case
184.6 manager shall provide documentation in each individual's plan and, if requested, to the
184.7 commissioner that the most cost-effective alternatives available have been offered to the
184.8 individual and that the individual was free to choose among available qualified providers,
184.9 both public and private, including qualified case management or service coordination
184.10 providers other than those employed by any county; however, the county or tribe maintains
184.11 responsibility for prior authorizing services in accordance with statutory and administrative
184.12 requirements. The case manager must give the individual a ten-day written notice of any
184.13 denial, termination, or reduction of alternative care services.

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

184.19 Sec. 130. Minnesota Statutes 2018, section 256B.73, subdivision 5, is amended to read:

184.20 Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider
184.21 shall receive a health services benefit package that includes health services which the
184.22 enrollees might reasonably require to be maintained in good health, including emergency
184.23 care, inpatient hospital and physician or advanced practice registered nurse care, outpatient
184.24 health services, and preventive health services.

184.25 (b) Services related to chemical dependency, mental illness, vision care, dental care,
184.26 and other benefits may be excluded or limited upon approval by the commissioners. The
184.27 coalition may petition the commissioner of commerce or health, whichever is appropriate,
184.28 for waivers that allow these benefits to be excluded or limited.

184.29 (c) The commissioners, the coalition, and demonstration providers shall work together
184.30 to design a package of benefits or packages of benefits that can be provided to enrollees for
184.31 an affordable monthly premium.

- 185.1 Sec. 131. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:
- 185.2 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a
- 185.3 "qualified professional" means a licensed physician, a physician assistant, ~~a nurse practitioner~~
- 185.4 an advanced practice registered nurse, or a licensed chiropractor.
- 185.5 (b) For developmental disability and intelligence testing, a "qualified professional"
- 185.6 means an individual qualified by training and experience to administer the tests necessary
- 185.7 to make determinations, such as tests of intellectual functioning, assessments of adaptive
- 185.8 behavior, adaptive skills, and developmental functioning. These professionals include
- 185.9 licensed psychologists, certified school psychologists, or certified psychometrists working
- 185.10 under the supervision of a licensed psychologist.
- 185.11 (c) For learning disabilities, a "qualified professional" means a licensed psychologist or
- 185.12 school psychologist with experience determining learning disabilities.
- 185.13 (d) For mental health, a "qualified professional" means a licensed physician or a qualified
- 185.14 mental health professional. A "qualified mental health professional" means:
- 185.15 (1) for children, in psychiatric nursing, a registered nurse or advanced practice registered
- 185.16 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
- 185.17 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
- 185.18 certification organization or who has a master's degree in nursing or one of the behavioral
- 185.19 sciences or related fields from an accredited college or university or its equivalent, with at
- 185.20 least 4,000 hours of post-master's supervised experience in the delivery of clinical services
- 185.21 in the treatment of mental illness;
- 185.22 (2) for adults, in psychiatric nursing, a registered nurse or advanced practice registered
- 185.23 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
- 185.24 specialist in adult psychiatric and mental health nursing by a national nurse certification
- 185.25 organization or who has a master's degree in nursing or one of the behavioral sciences or
- 185.26 related fields from an accredited college or university or its equivalent, with at least 4,000
- 185.27 hours of post-master's supervised experience in the delivery of clinical services in the
- 185.28 treatment of mental illness;
- 185.29 (3) in clinical social work, a person licensed as an independent clinical social worker
- 185.30 under chapter 148D, or a person with a master's degree in social work from an accredited
- 185.31 college or university, with at least 4,000 hours of post-master's supervised experience in
- 185.32 the delivery of clinical services in the treatment of mental illness;

186.1 (4) in psychology, an individual licensed by the Board of Psychology under sections
186.2 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis
186.3 and treatment of mental illness;

186.4 (5) in psychiatry, a physician licensed under chapter 147 and certified by the American
186.5 Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

186.6 (6) in marriage and family therapy, the mental health professional must be a marriage
186.7 and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of
186.8 post-master's supervised experience in the delivery of clinical services in the treatment of
186.9 mental illness; and

186.10 (7) in licensed professional clinical counseling, the mental health professional shall be
186.11 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours
186.12 of post-master's supervised experience in the delivery of clinical services in the treatment
186.13 of mental illness.

186.14 Sec. 132. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

186.15 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
186.16 **NECESSITY.**

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

186.24 (b) For a nursing facility with a total property payment rate determined under section
186.25 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established
186.26 total payment rate for a resident if the resident is a medical assistance recipient and the
186.27 private room is considered a medical necessity for the resident or others who are affected
186.28 by the resident's condition. Conditions requiring a private room must be determined by the
186.29 resident's attending physician or advanced practice registered nurse and submitted to the
186.30 commissioner for approval or denial by the commissioner on the basis of medical necessity.

187.1 Sec. 133. Minnesota Statutes 2018, section 256R.54, subdivision 1, is amended to read:

187.2 Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The
187.3 commissioner shall adopt rules under the Administrative Procedure Act to set the amount
187.4 and method of payment for ancillary materials and services provided to recipients residing
187.5 in nursing facilities. Payment for materials and services may be made to either the vendor
187.6 of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a
187.7 nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

187.8 (b) Payment for the same or similar service to a recipient shall not be made to both the
187.9 nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double
187.10 payments through audits and adjustments to the nursing facility's annual cost report as
187.11 required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements
187.12 for ancillary materials and services are cost-effective and as would be incurred by a prudent
187.13 and cost-conscious buyer.

187.14 (c) Therapy services provided to a recipient must be medically necessary and appropriate
187.15 to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician
187.16 or advanced practice registered nurse cannot provide adequate medical necessity justification,
187.17 as determined by the commissioner, the commissioner may recover or disallow the payment
187.18 for the services and may require prior authorization for therapy services as a condition of
187.19 payment or may impose administrative sanctions to limit the vendor, nursing facility, or
187.20 ordering physician's or advanced practice registered nurse's participation in the medical
187.21 assistance program. If the provider number of a nursing facility is used to bill services
187.22 provided by a vendor of therapy services that is not related to the nursing facility by
187.23 ownership, control, affiliation, or employment status, no withholding of payment shall be
187.24 imposed against the nursing facility for services not medically necessary except for funds
187.25 due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose
187.26 of this subdivision, no monetary recovery may be imposed against the nursing facility for
187.27 funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for
187.28 services not medically necessary.

187.29 (d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy
187.30 includes physical therapy, occupational therapy, speech therapy, audiology, and mental
187.31 health services that are covered services according to Minnesota Rules, parts 9505.0170 to
187.32 9505.0475.

187.33 (e) For purposes of this subdivision, "ancillary services" includes transportation defined
187.34 as a covered service in section 256B.0625, subdivision 17.

188.1 Sec. 134. Minnesota Statutes 2018, section 256R.54, subdivision 2, is amended to read:

188.2 Subd. 2. **Certification that treatment is appropriate.** The physical therapist,
188.3 occupational therapist, speech therapist, mental health professional, or audiologist who
188.4 provides or supervises the provision of therapy services, other than an initial evaluation, to
188.5 a medical assistance recipient must certify in writing that the therapy's nature, scope, duration,
188.6 and intensity are appropriate to the medical condition of the recipient every 30 days. The
188.7 therapist's statement of certification must be maintained in the recipient's medical record
188.8 together with the specific orders by the physician or advanced practice registered nurse and
188.9 the treatment plan. If the recipient's medical record does not include these documents, the
188.10 commissioner may recover or disallow the payment for such services. If the therapist
188.11 determines that the therapy's nature, scope, duration, or intensity is not appropriate to the
188.12 medical condition of the recipient, the therapist must provide a statement to that effect in
188.13 writing to the nursing facility for inclusion in the recipient's medical record. The
188.14 commissioner shall make recommendations regarding the medical necessity of services
188.15 provided.

188.16 Sec. 135. Minnesota Statutes 2018, section 257.63, subdivision 3, is amended to read:

188.17 Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered
188.18 nurse concerning the medical circumstances of the pregnancy itself and the condition and
188.19 characteristics of the child upon birth is not privileged.

188.20 Sec. 136. Minnesota Statutes 2018, section 257B.01, subdivision 3, is amended to read:

188.21 Subd. 3. **Attending physician or advanced practice registered nurse.** "Attending
188.22 physician or advanced practice registered nurse" means a physician or advanced practice
188.23 registered nurse who has primary responsibility for the treatment and care of the designator.
188.24 If physicians or advanced practice registered nurses share responsibility, another physician
188.25 or advanced practice registered nurse is acting on the attending physician's or advanced
188.26 practice registered nurse's behalf, or no physician or advanced practice registered nurse has
188.27 primary responsibility, any physician or advanced practice registered nurse who is familiar
188.28 with the designator's medical condition may act as an attending physician or advanced
188.29 practice registered nurse under this chapter.

188.30 Sec. 137. Minnesota Statutes 2018, section 257B.01, subdivision 9, is amended to read:

188.31 Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written
188.32 finding made by an attending physician or advanced practice registered nurse which states

189.1 that the designator suffers from a physically incapacitating disease or injury. No identification
189.2 of the illness in question is required.

189.3 Sec. 138. Minnesota Statutes 2018, section 257B.01, subdivision 10, is amended to read:

189.4 Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written
189.5 finding made by an attending physician or advanced practice registered nurse which states
189.6 the nature, extent, and probable duration of the designator's mental or organic incapacity.

189.7 Sec. 139. Minnesota Statutes 2018, section 257B.06, subdivision 7, is amended to read:

189.8 Subd. 7. **Restored capacity.** If a licensed physician or advanced practice registered
189.9 nurse determines that the designator has regained capacity, the co-custodian's authority that
189.10 commenced on the occurrence of a triggering event becomes inactive. Failure of a
189.11 co-custodian to immediately return the child(ren) to the designator's care entitles the
189.12 designator to an emergency hearing within five days of a request for a hearing.

189.13 Sec. 140. **REPEALER.**

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

189.15 Amend the title accordingly