Senator ..... moves to amend S.F. No. 3560 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2018, section 144.292, subdivision 2, is amended to read:

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

Sec. 2. Minnesota Statutes 2018, section 144.292, subdivision 5, is amended to read:

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

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

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

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

Sec. 3. Laws 2019, First Special Session chapter 9, article 11, section 35, the effective date, is amended to read:

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

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

ARTICLE 2
HEALTH RELATED LICENSING BOARDS

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

Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice nurse under section 148.235, a physician assistant under section ~~147A.18~~ 147A.185, or any other nonphysician health care provider authorized to prescribe the particular drug.

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

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

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

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

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

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

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

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

Subd. 21. **Prescription.** "Prescription" means a signed written order, an oral order reduced to writing, or an electronic order meeting current and prevailing standards given by a physician assistant ~~authorized to prescribe drugs~~ for patients in the course of the physician assistant's practice~~,~~ and issued for an individual patient ~~and containing the information required in the physician-physician assistant delegation agreement~~.

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

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

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

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

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

147A.02 QUALIFICATIONS FOR LICENSURE.

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

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

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

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

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

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

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

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

(7) has been approved by the board.

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

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

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

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

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

147A.05 INACTIVE LICENSE.

(a) Physician assistants who notify the board in writing may elect to place their license on an inactive status. Physician assistants with an inactive license shall be excused from payment of renewal fees and shall not practice as physician assistants. Persons who engage in practice while their license is lapsed or on inactive status shall be considered to be practicing without a license, which shall be grounds for discipline under section 147A.13. Physician assistants who provide care under the provisions of section 147A.23 shall not be considered practicing without a license or subject to disciplinary action. Physician assistants who notify the board of their intent to resume active practice shall be required to pay the current renewal fees and all unpaid back fees and shall be required to meet the criteria for renewal specified in section 147A.07.

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

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

147A.06 CANCELLATION OF LICENSE FOR NONRENEWAL.

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

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

(b) This subdivision expires July 1, 2022.

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

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

Subdivision 1. **Scope of practice.** Physician assistants shall practice medicine only ~~with physician supervision. Physician assistants may perform those duties and responsibilities~~

~~as delegated in the physician-physician assistant delegation agreement and delegation forms maintained at the address of record by the supervising physician and physician assistant, including the prescribing, administering, and dispensing of drugs, controlled substances, and medical devices, excluding anesthetics, other than local anesthetics, injected in connection with an operating room procedure, inhaled anesthesia and spinal anesthesia~~ under an established practice agreement.

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

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

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

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

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

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

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

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

(2) performing physical examinations;

(3) interpreting and evaluating patient data;

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

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

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

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

(8) creating and maintaining appropriate patient records;

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

(10) prescribing, administering, and dispensing drugs, controlled substances, and medical devices ~~if this function has been delegated by the supervising physician pursuant to and subject to the limitations of section 147A.18 and chapter 151. For physician assistants who have been delegated the authority to prescribe controlled substances, such delegation shall be included in the physician-physician assistant delegation agreement, and all schedules of controlled substances the physician assistant has the authority to prescribe shall be specified~~, and includes administering local anesthetics, but excluding anesthetics injected in connection with an operating room procedure, inhaled anesthesia, and spinal anesthesia;

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

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

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

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

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

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

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

Subd. 3. **Practice agreement review.** A physician assistant shall have a practice agreement at the practice level that describes the practice of the physician assistant. The practice agreement must be reviewed on an annual basis by a licensed physician within the same clinic, hospital, health system, or other facility as the physician assistant and has

knowledge of the physician assistant's practice to ensure that the physician assistant's medical practice is consistent with the practice agreement. A document stating that the review occurred must be maintained at the practice level and made available to the board, upon request.

Subd. 4. **Scope of practice limitations; spinal injections for acute and chronic pain.** Notwithstanding subdivision 1, a physician assistant may only perform spinal injections to address acute and chronic pain symptoms upon referral and in collaboration with a physician licensed under chapter 147. For purposes of performing spinal injections for acute or chronic pain symptoms, the physician assistant and one or more physicians licensed under chapter 147 must have a mutually agreed upon plan that designates the scope of collaboration necessary for treating patients with acute and chronic pain.

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

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

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

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

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

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

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

(3) conviction, during the previous five years, of a felony reasonably related to the practice of physician assistant. Conviction as used in this subdivision includes a conviction of an offense which if committed in this state would be deemed a felony without regard to

its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered;

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

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

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

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

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

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

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

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

~~(12)~~ (11) inability to practice with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material, or as

a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(23)~~ (22) ~~failure to maintain annually reviewed and updated physician-physician assistant delegation agreements for each physician-physician assistant practice relationship, or failure to provide copies of such documents upon request by the board~~ failure to maintain the proof of review document as required under section 147A.09, subdivision 3, or to provide a copy of the document upon request of the board.

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

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

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

147A.16 FORMS OF DISCIPLINARY ACTION.

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

(1) revoke the license;

(2) suspend the license;

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

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the physician assistant of any economic

advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the date of issue;

(2) the name and address of the patient;

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

(4) directions for use; and

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

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

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

147A.23 RESPONDING TO DISASTER SITUATIONS.

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

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

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

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

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, ~~or~~ licensed advanced practice registered nurse~~. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a~~, or licensed physician assistant ~~authorized to~~

~~prescribe, dispense, and administer under chapter 147A~~. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.For purposes of sections 151.252, subdivision 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered hormonal contraceptives, nicotine replacement medications, or opiate antagonists under section 151.37, subdivision 14, 15, or 16.

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

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

(1) interpretation and evaluation of prescription drug orders;

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

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

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

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

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

(ii) pursuant to a protocol or collaborative practice agreement as defined by section 151.01, subdivisions 27b and 27c, and participation in the initiation, management, modification, administration, and discontinuation of drug therapy is according to the protocol or collaborative practice agreement between the pharmacist and a dentist, optometrist, physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized

to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy or medication administration made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

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

(i) the protocol includes, at a minimum:

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

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

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

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

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

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

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

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

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

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe

drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) 18 years of age or older; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and

supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes.

Sec. 26. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2018, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical

care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

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

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

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

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

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

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

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

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

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

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

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

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

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting,

or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

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

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

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence.

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

Sec. 28. **REPEALER.**

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

ARTICLE 3
HEALTH CARE

Section 1. Minnesota Statutes 2018, section 62U.03, is amended to read:

62U.03 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

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

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

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

Sec. 2. Minnesota Statutes 2018, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2018, section 256.01, subdivision 29, is amended to read:

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

~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted by county agencies with a referral~~ and seek ~~additional~~ information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2018, section 256B.056, subdivision 1a, is amended to read:

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

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

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

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

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

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

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision ~~8~~ 1; and

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

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

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1)~~,~~:

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

(ii) the individual's current monthly income and household size is used to determine eligibility for the 12-month eligibility period. If an individual's income is expected to vary

month to month, eligibility is determined based on the income predicted for the 12-month eligibility period.

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

Sec. 5. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

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

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

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

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

(e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child under age 19 may have income up to 275 percent of the federal poverty guidelines for the household size ~~or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act. Children who are enrolled in medical assistance as of December 31, 2013, and are determined ineligible for medical assistance because of the elimination of income disregards under modified adjusted gross income methodology as defined in subdivision 1a remain eligible for medical assistance under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, until the date of their next regularly scheduled eligibility redetermination as required in subdivision 7a~~.

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

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

Sec. 6. Minnesota Statutes 2018, section 256B.056, subdivision 7, is amended to read:

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

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

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

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

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

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

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter. The local agency may close the enrollee's case file if the required information is not submitted within four months of termination.

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

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

Sec. 8. Minnesota Statutes 2018, section 256B.056, subdivision 10, is amended to read:

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2018, section 256B.0561, subdivision 2, is amended to read:

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2018, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a) An infant less than two years of age ~~or a pregnant woman~~ is eligible for medical assistance if the ~~individual's~~ infant's countable household income is equal to or less than ~~275~~ 283 percent of the federal poverty guideline for the same household size ~~or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act~~. Medical assistance for an uninsured infant younger than two years of age may be paid with federal

funds available under title XXI of the Social Security Act and the state children's health insurance program, for an infant with countable income above 275 percent and equal to or less than 283 percent of the federal poverty guideline for the household size.

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

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

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

Sec. 11. Minnesota Statutes 2018, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

(4) is under age 65;

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

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

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

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

Sec. 12. Minnesota Statutes 2018, section 256B.0575, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) if one of the following circumstances apply:

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

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

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

Sec. 13. Minnesota Statutes 2018, section 256B.0575, subdivision 2, is amended to read:

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

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 27, is amended to read:

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

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

Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 64, is amended to read:

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2018, section 256B.0751, is amended to read:

256B.0751 HEALTH CARE HOMES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. ~~In order~~ To be certified as a health care home, a clinician or clinic must meet the standards set by the ~~commissioners~~ commissioner in accordance with this section. Certification as a health care home is voluntary. ~~In order~~ To maintain their status as health care homes, clinicians or clinics must renew their certification every three years.

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

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

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

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

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

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

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

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

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, and housing. The

coordination of care and services must be as provided in the plan established by the patient and the health care home.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2018, section 256B.0753, subdivision 1, is amended to read:

Subdivision 1. **Development.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to health care homes certified under section 256B.0751 for providing care coordination services and directly managing on-site or employing care coordinators. The care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. ~~Development of the payment system must be completed by January 1, 2010.~~

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

Sec. 19. Minnesota Statutes 2018, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,

or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

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

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

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

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

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

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

Sec. 20. Minnesota Statutes 2018, section 256L.03, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 21. Minnesota Statutes 2018, section 256L.15, subdivision 1, is amended to read:

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

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

(c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must indicate status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The commissioner shall accept attestation of an individual's status as an American Indian as verification until the United States Department of Health and Human Services approves an electronic data source for this purpose.

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

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

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

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

Sec. 22. **REVISOR INSTRUCTION.**

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

Column A	Column B
256B.0751, subdivision 1	62U.03, subdivision 2
256B.0751, subdivision 2	62U.03, subdivision 3
256B.0751, subdivision 3	62U.03, subdivision 4
256B.0751, subdivision 4	62U.03, subdivision 5
256B.0751, subdivision 5	62U.03, subdivision 6
256B.0751, subdivision 6	62U.03, subdivision 7
256B.0751, subdivision 7	62U.03, subdivision 8
256B.0751, subdivision 8	62U.03, subdivision 9
256B.0751, subdivision 9	62U.03, subdivision 10
256B.0751, subdivision 10	62U.03, subdivision 11

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

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

Sec. 23. **REPEALER.**

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

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

ARTICLE 4
ADVANCED PRACTICE REGISTERED NURSE PROVISIONS

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

Subdivision 1. **Marketing requirements.** (a) Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of enrollee

information and rights as described in section 62D.07, subdivision 3, clauses (2) and (3). Prior to any oral marketing presentation, the agent marketing the plan must inform the potential enrollees that any complaints concerning the material presented should be directed to the health maintenance organization, the commissioner of health, or, if applicable, the employer.

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

(1) health care services not provided;

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

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

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

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

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

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

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

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include

a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall not be subject to a lifetime maximum on essential health benefits.

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

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

(1) hospital services;

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

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

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

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

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

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

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

(11) diagnostic x-rays and laboratory tests;

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

(13) services of a physical therapist;

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

(15) services of an occupational therapist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) activities permitted under paragraph (b);

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

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

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

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

Sec. 5. Minnesota Statutes 2018, section 62J.495, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

(b) "Commissioner" means the commissioner of health.

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third-party administrators, and pharmacy benefit managers in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

(2) support ~~physician~~ provider order entry;

(3) capture and query information relevant to health care quality; and

(4) exchange electronic health information with, and integrate such information from, other sources.

Sec. 6. Minnesota Statutes 2018, section 62J.52, subdivision 2, is amended to read:

Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the most current version of the health insurance claim form CMS 1500.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the Administrative Uniformity Committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, ~~nursing practitioner professional services, certified registered nurse anesthetists~~ advanced practice registered nurse services, chiropractors, physician assistants, laboratories, medical suppliers, waivered services, personal care attendants, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 7. Minnesota Statutes 2018, section 62J.823, subdivision 3, is amended to read:

Subd. 3. **Applicability and scope.** Any hospital, as defined in section 144.696, subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4, shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, advanced practice registered nurse, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2018, section 62Q.43, subdivision 1, is amended to read:

Subdivision 1. **Closed-panel health plan.** For purposes of this section, "closed-panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to receive all or a majority of primary care services from a specific clinic or ~~physician~~ primary care provider designated by the enrollee that is within the health plan company's clinic or ~~physician~~ provider network.

Sec. 10. Minnesota Statutes 2018, section 62Q.43, subdivision 2, is amended to read:

Subd. 2. **Access requirement.** Every closed-panel health plan must allow enrollees under the age of 26 years to change their designated clinic or ~~physician~~ primary care provider at least once per month, as long as the clinic or ~~physician~~ provider is part of the health plan company's statewide clinic or ~~physician~~ provider network. A health plan company shall not charge enrollees who choose this option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days' written notice of intent to change their designated clinic or ~~physician~~ primary care provider.

Sec. 11. Minnesota Statutes 2018, section 62Q.54, is amended to read:

62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.

If an enrollee is a resident of a health care facility licensed under chapter 144A or a housing with services establishment registered under chapter 144D, the enrollee's primary care ~~physician~~ provider must refer the enrollee to that facility's skilled nursing unit or that facility's appropriate care setting, provided that the health plan company and the provider can best meet the patient's needs in that setting, if the following conditions are met:

(1) the facility agrees to be reimbursed at that health plan company's contract rate negotiated with similar providers for the same services and supplies; and

(2) the facility meets all guidelines established by the health plan company related to quality of care, utilization, referral authorization, risk assumption, use of health plan company network, and other criteria applicable to providers under contract for the same services and supplies.

Sec. 12. Minnesota Statutes 2018, section 62Q.57, subdivision 1, is amended to read:

Subdivision 1. **Choice of primary care provider.** (a) If a health plan company offering a group health plan, or an individual health plan that is not a grandfathered plan, requires

or provides for the designation by an enrollee of a participating primary care provider, the health plan company shall permit each enrollee to:

(1) designate any participating primary care provider available to accept the enrollee; and

(2) for a child, designate any participating physician or advanced practice registered nurse who specializes in pediatrics as the child's primary care provider and is available to accept the child.

(b) This section does not waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care.

Sec. 13. Minnesota Statutes 2018, section 62Q.73, subdivision 7, is amended to read:

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records, the attending physician, advanced practice registered nurse, or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Sec. 14. Minnesota Statutes 2018, section 62Q.733, subdivision 3, is amended to read:

Subd. 3. **Health care provider or provider.** "Health care provider" or "provider" means a physician, advanced practice registered nurse, chiropractor, dentist, podiatrist, or other provider as defined under section 62J.03, other than hospitals, ambulatory surgical centers, or freestanding emergency rooms.

Sec. 15. Minnesota Statutes 2018, section 62Q.74, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, "category of coverage" means one of the following types of health-related coverage:

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

(b) "Health care provider" or "provider" means a physician, advanced practice registered nurse, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding emergency room, or other provider, as defined in section 62J.03.

Sec. 16. Minnesota Statutes 2018, section 62S.08, subdivision 3, is amended to read:

Subd. 3. **Mandatory format.** The following standard format outline of coverage must be used, unless otherwise specifically indicated:

COMPANY NAME

ADDRESS - CITY AND STATE

TELEPHONE NUMBER

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

Policy Number or Group Master Policy and Certificate Number

(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy.

The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

(1) This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued).

(2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

(3) THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE OF 1986.

(4) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) (For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:)

(1) (Policies and certificates that are guaranteed renewable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, (certificate) to continue this policy as long as you pay your premiums on time. (Company name) cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) (Policies and certificates that are noncancelable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. (Company name) cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, (company name) may increase your premium at that time for those additional benefits.

(b) (For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.)

(c) (Describe waiver of premium provisions or state that there are not such provisions.)

(5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

(In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.)

(6) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) (Provide a brief description of the right to return -- "free look" provision of the policy.)

(b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

(7) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) neither (insert company name) nor its agents represent Medicare, the federal government, or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government, or any state government.

(8) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations), (waiting periods), and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

(9) BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(d) (Eligibility for payment of benefits.)

(Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician, advanced practice registered nurse, or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

(10) LIMITATIONS AND EXCLUSIONS:

Describe:

(a) preexisting conditions;

(b) noneligible facilities/provider;

(c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) exclusions/exceptions; and

(e) limitations.

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (8).)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

(11) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. As applicable, indicate the following:

(a) that the benefit level will not increase over time;

(b) any automatic benefit adjustment provisions;

(c) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) if there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and

(e) whether there will be any additional premium charge imposed and how that is to be calculated.

(12) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. (State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically, describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

(13) PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

(14) ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

(15) CONTACT THE STATE DEPARTMENT OF COMMERCE OR SENIOR LINKAGE LINE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Sec. 17. Minnesota Statutes 2018, section 62S.20, subdivision 5b, is amended to read:

Subd. 5b. **Benefit triggers.** Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be described in the policy or certificate in a separate paragraph and must be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained in this section. If these

triggers differ for different benefits, explanation of the trigger must accompany each benefit description. If an attending physician, advanced practice registered nurse, or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

Sec. 18. Minnesota Statutes 2018, section 62S.21, subdivision 2, is amended to read:

Subd. 2. **Medication information required.** If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician or advanced practice registered nurse, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

Sec. 19. Minnesota Statutes 2018, section 62S.268, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, an advanced practice registered nurse, a registered professional

nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

Sec. 20. Minnesota Statutes 2018, section 144.3345, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The following definitions are used for the purposes of this section.

(b) "Eligible community e-health collaborative" means an existing or newly established collaborative to support the adoption and use of interoperable electronic health records. A collaborative must consist of at least two or more eligible health care entities in at least two of the categories listed in paragraph (c) and have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

(c) "Eligible health care entity" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician or advanced practice registered nurse clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven-county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27;

(5) community health boards as established under chapter 145A;

(6) nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi-stakeholder board of directors; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

Sec. 21. Minnesota Statutes 2018, section 144.3352, is amended to read:

144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT IMMUNIZATION.

The commissioner of health or a community health board may inform the physician or advanced practice registered nurse attending a newborn of the hepatitis B infection status of the biological mother.

Sec. 22. Minnesota Statutes 2018, section 144.34, is amended to read:

144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.

Any physician or advanced practice registered nurse having under professional care any person whom the physician or advanced practice registered nurse believes to be suffering from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas, wood alcohol, or mercury, or their compounds, or from anthrax or from compressed-air illness or any other disease contracted as a result of the nature of the employment of such person shall within five days mail to the Department of Health a report stating the name, address, and occupation of such patient, the name, address, and business of the patient's employer, the nature of the disease, and such other information as may reasonably be required by the department. The department shall prepare and furnish the physicians and advanced practice registered nurses of this state suitable blanks for the reports herein required. No report made pursuant to the provisions of this section shall be admissible as evidence of the facts therein stated in any action at law or in any action under the Workers' Compensation Act against any employer of such diseased person. The Department of Health is authorized to investigate and to make recommendations for the elimination or prevention of occupational diseases which have been reported to it, or which shall be reported to it, in accordance with the provisions of this section. The department is also authorized to study and provide advice in regard to conditions that may be suspected of causing occupational diseases. Information obtained upon investigations made in accordance with the provisions of this section shall not be admissible as evidence in any action at law to recover damages for personal injury or in any action under the Workers' Compensation Act. Nothing herein contained shall be construed to interfere with or limit the powers of the Department of Labor and Industry to make inspections of places of employment or issue orders for the protection of the health of the persons therein employed. When upon investigation the commissioner of health reaches a conclusion that a condition exists which is dangerous to the life and health of the workers in any industry or factory or other industrial institutions the commissioner shall file a report thereon with the Department of Labor and Industry.

Sec. 23. Minnesota Statutes 2018, section 144.441, subdivision 4, is amended to read:

Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision 2, a person employed by the designated school or school district shall submit to the administrator or other person having general control and supervision of the school one of the following:

(1) a statement from a physician, advanced practice registered nurse, or public clinic stating that the person has had a negative Mantoux test reaction within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(2) a statement from a physician, advanced practice registered nurse, or public clinic stating that a person who has a positive Mantoux test reaction has had a negative chest roentgenogram (X-ray) for tuberculosis within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(3) a statement from a physician, advanced practice registered nurse, or public health clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii) is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy for active tuberculosis and the person's presence in a school building will not endanger the health of other people; or (iv) has completed a course of preventive therapy or was intolerant to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; or

(4) a notarized statement signed by the person stating that the person has not submitted the proof of tuberculosis screening as required by this subdivision because of conscientiously held beliefs. This statement must be forwarded to the commissioner of health.

Sec. 24. Minnesota Statutes 2018, section 144.441, subdivision 5, is amended to read:

Subd. 5. **Exceptions.** Subdivisions 3 and 4 do not apply to:

(1) a person with a history of either a past positive Mantoux test reaction or active tuberculosis who has a documented history of completing a course of tuberculosis therapy or preventive therapy when the school or school district holds a statement from a physician, advanced practice registered nurse, or public health clinic indicating that such therapy was provided to the person and that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; and

(2) a person with a history of a past positive Mantoux test reaction who has not completed a course of preventive therapy. This determination shall be made by the commissioner based on currently accepted public health standards and the person's health status.

Sec. 25. Minnesota Statutes 2018, section 144.442, subdivision 1, is amended to read:

Subdivision 1. **Administration; notification.** In the event that the commissioner designates a school or school district under section 144.441, subdivision 2, the school or school district or community health board may administer Mantoux screening tests to some or all persons enrolled in or employed by the designated school or school district. Any Mantoux screening provided under this section shall be under the direction of a licensed physician or advanced practice registered nurse.

Prior to administering the Mantoux test to such persons, the school or school district or community health board shall inform in writing such persons and parents or guardians of minor children to whom the test may be administered, of the following:

(1) that there has been an occurrence of active tuberculosis or evidence of a higher than expected prevalence of tuberculosis infection in that school or school district;

(2) that screening is necessary to avoid the spread of tuberculosis;

(3) the manner by which tuberculosis is transmitted;

(4) the risks and possible side effects of the Mantoux test;

(5) the risks from untreated tuberculosis to the infected person and others;

(6) the ordinary course of further diagnosis and treatment if the Mantoux test is positive;

(7) that screening has been scheduled; and

(8) that no person will be required to submit to the screening if the person submits a statement of objection due to the conscientiously held beliefs of the person employed or of the parent or guardian of a minor child.

Sec. 26. Minnesota Statutes 2018, section 144.4803, subdivision 1, is amended to read:

Subdivision 1. **Active tuberculosis.** "Active tuberculosis" includes infectious and noninfectious tuberculosis and means:

(1) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from a pulmonary or laryngeal source;

(2) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from an extrapulmonary source when there is clinical evidence such as a positive skin test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with pulmonary tuberculosis; or

(3) a condition in which clinical specimens are not available for culture, but there is radiographic evidence of tuberculosis such as an abnormal chest x-ray, and clinical evidence such as a positive skin test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with pulmonary tuberculosis, that lead a physician or advanced practice registered nurse to reasonably diagnose active tuberculosis according to currently accepted standards of medical practice and to initiate treatment for tuberculosis.

Sec. 27. Minnesota Statutes 2018, section 144.4803, is amended by adding a subdivision to read:

Subd. 1a. **Advanced practice registered nurse.** "Advanced practice registered nurse" means a person who is licensed by the Board of Nursing under chapter 148 to practice as an advanced practice registered nurse.

Sec. 28. Minnesota Statutes 2018, section 144.4803, subdivision 4, is amended to read:

Subd. 4. **Clinically suspected of having active tuberculosis.** "Clinically suspected of having active tuberculosis" means presenting a reasonable possibility of having active tuberculosis based upon epidemiologic, clinical, or radiographic evidence, laboratory test results, or other reliable evidence as determined by a physician or advanced practice registered nurse using currently accepted standards of medical practice.

Sec. 29. Minnesota Statutes 2018, section 144.4803, subdivision 10, is amended to read:

Subd. 10. **Endangerment to the public health.** "Endangerment to the public health" means a carrier who may transmit tuberculosis to another person or persons because the carrier has engaged or is engaging in any of the following conduct:

(1) refuses or fails to submit to a diagnostic tuberculosis examination that is ordered by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(2) refuses or fails to initiate or complete treatment for tuberculosis that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(3) refuses or fails to keep appointments for treatment of tuberculosis;

(4) refuses or fails to provide the commissioner, upon request, with evidence showing the completion of a course of treatment for tuberculosis that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(5) refuses or fails to initiate or complete a course of directly observed therapy that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(6) misses at least 20 percent of scheduled appointments for directly observed therapy, or misses at least two consecutive appointments for directly observed therapy;

(7) refuses or fails to follow contagion precautions for tuberculosis after being instructed on the precautions by a licensed health professional or by the commissioner;

(8) based on evidence of the carrier's past or present behavior, may not complete a course of treatment for tuberculosis that is reasonable according to currently accepted standards of medical practice; or

(9) may expose other persons to tuberculosis based on epidemiological, medical, or other reliable evidence.

Sec. 30. Minnesota Statutes 2018, section 144.4806, is amended to read:

144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.

A health order may include, but need not be limited to, an order:

(1) requiring the carrier's attending physician, advanced practice registered nurse, or treatment facility to isolate and detain the carrier for treatment or for a diagnostic examination for tuberculosis, pursuant to section 144.4807, subdivision 1, if the carrier is an endangerment to the public health and is in a treatment facility;

(2) requiring a carrier who is an endangerment to the public health to submit to diagnostic examination for tuberculosis and to remain in the treatment facility until the commissioner receives the results of the examination;

(3) requiring a carrier who is an endangerment to the public health to remain in or present at a treatment facility until the carrier has completed a course of treatment for tuberculosis that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(4) requiring a carrier who is an endangerment to the public health to complete a course of treatment for tuberculosis that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice and, if necessary, to follow contagion precautions for tuberculosis;

(5) requiring a carrier who is an endangerment to the public health to follow a course of directly observed therapy that is prescribed by a physician or advanced practice registered nurse and is reasonable according to currently accepted standards of medical practice;

(6) excluding a carrier who is an endangerment to the public health from the carrier's place of work or school, or from other premises if the commissioner determines that exclusion is necessary because contagion precautions for tuberculosis cannot be maintained in a manner adequate to protect others from being exposed to tuberculosis;

(7) requiring a licensed health professional or treatment facility to provide to the commissioner certified copies of all medical and epidemiological data relevant to the carrier's tuberculosis and status as an endangerment to the public health;

(8) requiring the diagnostic examination for tuberculosis of other persons in the carrier's household, workplace, or school, or other persons in close contact with the carrier if the commissioner has probable cause to believe that the persons may have active tuberculosis or may have been exposed to tuberculosis based on epidemiological, medical, or other reliable evidence; or

(9) requiring a carrier or other persons to follow contagion precautions for tuberculosis.

Sec. 31. Minnesota Statutes 2018, section 144.4807, subdivision 1, is amended to read:

Subdivision 1. **Obligation to isolate.** If the carrier is in a treatment facility, the commissioner or a carrier's attending physician or advanced practice registered nurse, after obtaining approval from the commissioner, may issue a notice of obligation to isolate to a treatment facility if the commissioner or attending physician or advanced practice registered nurse has probable cause to believe that a carrier is an endangerment to the public health.

Sec. 32. Minnesota Statutes 2018, section 144.4807, subdivision 2, is amended to read:

Subd. 2. **Obligation to examine.** If the carrier is clinically suspected of having active tuberculosis, the commissioner may issue a notice of obligation to examine to the carrier's attending physician or advanced practice registered nurse to conduct a diagnostic examination for tuberculosis on the carrier.

Sec. 33. Minnesota Statutes 2018, section 144.4807, subdivision 4, is amended to read:

Subd. 4. **Service of health order on carrier.** When issuing a notice of obligation to isolate or examine to the carrier's physician or advanced practice registered nurse or a treatment facility, the commissioner shall simultaneously serve a health order on the carrier ordering the carrier to remain in the treatment facility for treatment or examination.

Sec. 34. Minnesota Statutes 2018, section 144.50, subdivision 2, is amended to read:

Subd. 2. **Hospital, sanitarium, other institution; definition.** Hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for five or more persons for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's or advanced practice registered nurse's office or to hotels or other similar places that furnish only board and room, or either, to their guests.

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

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

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

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

Sec. 36. Minnesota Statutes 2018, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice registered nurses who have a "financial or economic interest," as defined in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

Sec. 37. Minnesota Statutes 2018, section 144.6501, subdivision 7, is amended to read:

Subd. 7. **Consent to treatment.** An admission contract must not include a clause requiring a resident to sign a consent to all treatment ordered by any physician or advanced practice registered nurse. An admission contract may require consent only for routine nursing care or emergency care. An admission contract must contain a clause that informs the resident of the right to refuse treatment.

Sec. 38. Minnesota Statutes 2018, section 144.651, subdivision 7, is amended to read:

Subd. 7. **Physician's or advanced practice registered nurse's identity.** Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician or advanced practice registered nurse responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician or advanced practice registered nurse in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Sec. 39. Minnesota Statutes 2018, section 144.651, subdivision 8, is amended to read:

Subd. 8. **Relationship with other health services.** Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their

facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician or advanced practice registered nurse in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Sec. 40. Minnesota Statutes 2018, section 144.651, subdivision 9, is amended to read:

Subd. 9. **Information about treatment.** Patients and residents shall be given by their physicians or advanced practice registered nurses complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's or advanced practice registered nurse's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician or advanced practice registered nurse in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician or advanced practice registered nurse is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

Sec. 41. Minnesota Statutes 2018, section 144.651, subdivision 10, is amended to read:

Subd. 10. **Participation in planning treatment; notification of family members.** (a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an advance directive relative to the patient or resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the patient or resident;

(2) examining the medical records of the patient or resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the patient or resident has executed an advance directive and whether the patient or resident has a physician or advanced practice registered nurse to whom the patient or resident normally goes for care; and

(4) inquiring of the physician or advanced practice registered nurse to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family

member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Sec. 42. Minnesota Statutes 2018, section 144.651, subdivision 12, is amended to read:

Subd. 12. **Right to refuse care.** Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician or advanced practice registered nurse in the patient's or resident's medical record.

Sec. 43. Minnesota Statutes 2018, section 144.651, subdivision 14, is amended to read:

Subd. 14. **Freedom from maltreatment.** Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician or advanced practice registered nurse for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Sec. 44. Minnesota Statutes 2018, section 144.651, subdivision 31, is amended to read:

Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, advanced practice

registered nurse, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

Sec. 45. Minnesota Statutes 2018, section 144.651, subdivision 33, is amended to read:

Subd. 33. **Restraints.** (a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians, and health care agents as defined under section 145C.01, have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident.

(b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use. The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician or advanced practice registered nurse that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used.

(c) A nursing home providing a restraint under paragraph (b) must:

(1) document that the procedures outlined in that paragraph have been followed;

(2) monitor the use of the restraint by the resident; and

(3) periodically, in consultation with the resident, the family, and the attending physician or advanced practice registered nurse, reevaluate the resident's need for the restraint.

(d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the commissioner from taking action to protect the health and safety of a resident if:

(1) the use of the restraint has jeopardized the health and safety of the resident; and

(2) the nursing home failed to take reasonable measures to protect the health and safety of the resident.

(e) For purposes of this subdivision, "medical symptoms" include:

(1) a concern for the physical safety of the resident; and

(2) physical or psychological needs expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

A written order from the attending physician or advanced practice registered nurse that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint.

(f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's or advanced practice registered nurse's order regarding medical symptoms. For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C.01, that the facility provide a physical restraint in order to enhance the physical safety of the resident.

Sec. 46. Minnesota Statutes 2018, section 144.652, subdivision 2, is amended to read:

Subd. 2. **Correction order; emergencies.** A substantial violation of the rights of any patient or resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf of a patient or resident to enforce any unreasonable violation of the patient's or resident's rights. Compliance with the provisions of section 144.651 shall not be required whenever emergency conditions, as documented by the attending physician or advanced practice registered nurse in a patient's medical record or a resident's care record, indicate immediate medical treatment, including but not limited to surgical procedures, is necessary and it is impossible or impractical to comply with the provisions of section 144.651 because delay would endanger the patient's or resident's life, health, or safety.

Sec. 47. Minnesota Statutes 2018, section 144.69, is amended to read:

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer surveillance system, including the names and personal identifiers of persons required in section 144.68 to report, shall be private and may only be used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure other than is provided for in this section and sections 144.671, 144.672, and 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by rule, and as part of an epidemiologic investigation, an officer or employee of the commissioner of health may interview patients named in any such report, or relatives of

any such patient, only after the consent of the attending physician, advanced practice registered nurse, or surgeon is obtained.

Sec. 48. Minnesota Statutes 2018, section 144.7402, subdivision 2, is amended to read:

Subd. 2. **Conditions.** A facility shall follow the procedures outlined in sections 144.7401 to 144.7415 when all of the following conditions are met:

(1) the facility determines that significant exposure has occurred, following the protocol under section 144.7414;

(2) the licensed physician or advanced practice registered nurse for the emergency medical services person needs the source individual's blood-borne pathogen test results to begin, continue, modify, or discontinue treatment, in accordance with the most current guidelines of the United States Public Health Service, because of possible exposure to a blood-borne pathogen; and

(3) the emergency medical services person consents to provide a blood sample for testing for a blood-borne pathogen. If the emergency medical services person consents to blood collection, but does not consent at that time to blood-borne pathogen testing, the facility shall preserve the sample for at least 90 days. If the emergency medical services person elects to have the sample tested within 90 days, the testing shall be done as soon as feasible.

Sec. 49. Minnesota Statutes 2018, section 144.7406, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** If the source individual has provided a blood sample with consent but does not consent to blood-borne pathogen testing, the facility shall test for blood-borne pathogens if the emergency medical services person or emergency medical services agency requests the test, provided all of the following criteria are met:

(1) the emergency medical services person or emergency medical services agency has documented exposure to blood or body fluids during performance of that person's occupation or while acting as a Good Samaritan under section 604A.01 or executing a citizen's arrest under section 629.30;

(2) the facility has determined that a significant exposure has occurred and a licensed physician or advanced practice registered nurse for the emergency medical services person has documented in the emergency medical services person's medical record that blood-borne pathogen test results are needed for beginning, modifying, continuing, or discontinuing medical treatment for the emergency medical services person under section 144.7414, subdivision 2;

(3) the emergency medical services person provides a blood sample for testing for blood-borne pathogens as soon as feasible;

(4) the facility asks the source individual to consent to a test for blood-borne pathogens and the source individual does not consent;

(5) the facility has provided the source individual with all of the information required by section 144.7403; and

(6) the facility has informed the emergency medical services person of the confidentiality requirements of section 144.7411 and the penalties for unauthorized release of source information under section 144.7412.

Sec. 50. Minnesota Statutes 2018, section 144.7407, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** (a) An emergency medical services agency, or, if there is no agency, an emergency medical services person, may bring a petition for a court order to require a source individual to provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in the district court in the county where the source individual resides or is hospitalized. The petitioner shall serve the petition on the source individual at least three days before a hearing on the petition. The petition shall include one or more affidavits attesting that:

(1) the facility followed the procedures in sections 144.7401 to 144.7415 and attempted to obtain blood-borne pathogen test results according to those sections;

(2) it has been determined under section 144.7414, subdivision 2, that a significant exposure has occurred to the emergency medical services person; and

(3) a physician with specialty training in infectious diseases, including HIV, has documented that the emergency medical services person has provided a blood sample and consented to testing for blood-borne pathogens and blood-borne pathogen test results are needed for beginning, continuing, modifying, or discontinuing medical treatment for the emergency medical services person.

(b) Facilities shall cooperate with petitioners in providing any necessary affidavits to the extent that facility staff can attest under oath to the facts in the affidavits.

(c) The court may order the source individual to provide a blood sample for blood-borne pathogen testing if:

(1) there is probable cause to believe the emergency medical services person has experienced a significant exposure to the source individual;

(2) the court imposes appropriate safeguards against unauthorized disclosure that must specify the persons who have access to the test results and the purposes for which the test results may be used;

(3) a licensed physician or advanced practice registered nurse for the emergency medical services person needs the test results for beginning, continuing, modifying, or discontinuing medical treatment for the emergency medical services person; and

(4) the court finds a compelling need for the test results. In assessing compelling need, the court shall weigh the need for the court-ordered blood collection and test results against the interests of the source individual, including, but not limited to, privacy, health, safety, or economic interests. The court shall also consider whether the involuntary blood collection and testing would serve the public interest.

(d) The court shall conduct the proceeding in camera unless the petitioner or the source individual requests a hearing in open court and the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) The court shall conduct an ex parte hearing if the source individual does not attend the noticed hearing and the petitioner complied with the notice requirements in paragraph (a).

(f) The source individual has the right to counsel in any proceeding brought under this subdivision.

(g) The court may order a source individual taken into custody by a peace officer for purposes of obtaining a blood sample if the source individual does not comply with an order issued by the court pursuant to paragraph (c). The source individual shall be held no longer than is necessary to secure a blood sample. A person may not be held for more than 24 hours without receiving a court hearing.

Sec. 51. Minnesota Statutes 2018, section 144.7414, subdivision 2, is amended to read:

Subd. 2. **Facility protocol requirements.** Every facility shall adopt and follow a postexposure protocol for emergency medical services persons who have experienced a significant exposure. The postexposure protocol must adhere to the most current recommendations of the United States Public Health Service and include, at a minimum, the following:

(1) a process for emergency medical services persons to report an exposure in a timely fashion;

(2) a process for an infectious disease specialist, or a licensed physician or advanced practice registered nurse who is knowledgeable about the most current recommendations of the United States Public Health Service in consultation with an infectious disease specialist, (i) to determine whether a significant exposure to one or more blood-borne pathogens has occurred and (ii) to provide, under the direction of a licensed physician or advanced practice registered nurse, a recommendation or recommendations for follow-up treatment appropriate to the particular blood-borne pathogen or pathogens for which a significant exposure has been determined;

(3) if there has been a significant exposure, a process to determine whether the source individual has a blood-borne pathogen through disclosure of test results, or through blood collection and testing as required by sections 144.7401 to 144.7415;

(4) a process for providing appropriate counseling prior to and following testing for a blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and follow-up recommendations according to the most current recommendations of the United States Public Health Service, recommendations for testing, and treatment to the emergency medical services person;

(5) a process for providing appropriate counseling under clause (4) to the emergency medical services person and the source individual; and

(6) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights.

Sec. 52. Minnesota Statutes 2018, section 144.7415, subdivision 2, is amended to read:

Subd. 2. **Immunity.** A facility, licensed physician, advanced practice registered nurse, and designated health care personnel are immune from liability in any civil, administrative, or criminal action relating to the disclosure of test results to an emergency medical services person or emergency medical services agency and the testing of a blood sample from the source individual for blood-borne pathogens if a good faith effort has been made to comply with sections 144.7401 to 144.7415.

Sec. 53. Minnesota Statutes 2018, section 144.9502, subdivision 4, is amended to read:

Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis reports required in this section must specify:

(1) whether the specimen was collected as a capillary or venous sample;

(2) the date the sample was collected;

(3) the results of the blood lead analysis;

(4) the date the sample was analyzed;

(5) the method of analysis used;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the physician, advanced practice registered nurse, or facility requesting the analysis;

(8) the full name, address, and phone number of the person with the blood lead level, and the person's birthdate, gender, and race.

Sec. 54. Minnesota Statutes 2018, section 144.966, subdivision 3, is amended to read:

Subd. 3. **Early hearing detection and intervention programs.** All hospitals shall establish an early hearing detection and intervention (EHDI) program. Each EHDI program shall:

(1) in advance of any hearing screening testing, provide to the newborn's or infant's parents or parent information concerning the nature of the screening procedure, applicable costs of the screening procedure, the potential risks and effects of hearing loss, and the benefits of early detection and intervention;

(2) comply with parental election as described under section 144.125, subdivision 4;

(3) develop policies and procedures for screening and rescreening based on Department of Health recommendations;

(4) provide appropriate training and monitoring of individuals responsible for performing hearing screening tests as recommended by the Department of Health;

(5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain in the hospital for a prolonged period, testing shall be performed prior to three months of age or when medically feasible;

(6) develop and implement procedures for documenting the results of all hearing screening tests;

(7) inform the newborn's or infant's parents or parent, primary care physician or advanced practice registered nurse, and the Department of Health according to recommendations of the Department of Health of the results of the hearing screening test or rescreening if conducted, or if the newborn or infant was not successfully tested. The hospital that discharges the newborn or infant to home is responsible for the screening; and

(8) collect performance data specified by the Department of Health.

Sec. 55. Minnesota Statutes 2018, section 144.966, subdivision 6, is amended to read:

Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician, advanced practice registered nurse, or hospital shall be civilly or criminally liable for failure to conduct hearing screening testing.

(b) No physician, midwife, nurse, other health professional, or hospital acting in compliance with this section shall be civilly or criminally liable for any acts conforming with this section, including furnishing information required according to this section.

Sec. 56. Minnesota Statutes 2018, section 144A.135, is amended to read:

144A.135 TRANSFER AND DISCHARGE APPEALS.

(a) The commissioner shall establish a mechanism for hearing appeals on transfers and discharges of residents by nursing homes or boarding care homes licensed by the commissioner. The commissioner may adopt permanent rules to implement this section.

(b) Until federal regulations are adopted under sections 1819(f)(3) and 1919(f)(3) of the Social Security Act that govern appeals of the discharges or transfers of residents from nursing homes and boarding care homes certified for participation in Medicare or medical assistance, the commissioner shall provide hearings under sections 14.57 to 14.62 and the rules adopted by the Office of Administrative Hearings governing contested cases. To appeal the discharge or transfer, or notification of an intended discharge or transfer, a resident or the resident's representative must request a hearing in writing no later than 30 days after receiving written notice, which conforms to state and federal law, of the intended discharge or transfer.

(c) Hearings under this section shall be held no later than 14 days after receipt of the request for hearing, unless impractical to do so or unless the parties agree otherwise. Hearings shall be held in the facility in which the resident resides, unless impractical to do so or unless the parties agree otherwise.

(d) A resident who timely appeals a notice of discharge or transfer, and who resides in a certified nursing home or boarding care home, may not be discharged or transferred by the nursing home or boarding care home until resolution of the appeal. The commissioner can order the facility to readmit the resident if the discharge or transfer was in violation of state or federal law. If the resident is required to be hospitalized for medical necessity before resolution of the appeal, the facility shall readmit the resident unless the resident's attending

physician or advanced practice registered nurse documents, in writing, why the resident's specific health care needs cannot be met in the facility.

(e) The commissioner and Office of Administrative Hearings shall conduct the hearings in compliance with the federal regulations described in paragraph (b), when adopted.

(f) Nothing in this section limits the right of a resident or the resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care or the Office of Health Facility Complaints with respect to an intended discharge or transfer.

(g) A person required to inform a health care facility of the person's status as a registered predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so shall be deemed to have endangered the safety of individuals in the facility under Code of Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal of the notice and discharge shall not constitute a stay of the discharge.

Sec. 57. Minnesota Statutes 2018, section 144A.161, subdivision 5, is amended to read:

Subd. 5. **Licensee responsibilities related to sending the notice in subdivision 5a.** (a) The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan. The interdisciplinary team shall include representatives from the county social services agency, the Office of Ombudsman for Long-Term Care, the Office of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that provide direct care services to the residents, and facility administration.

(b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide an updated resident census summary document to the county social services agency, the Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental Disabilities that includes the following information on each resident to be relocated:

(1) resident name;

(2) date of birth;

(3) Social Security number;

(4) payment source and medical assistance identification number, if applicable;

(5) county of financial responsibility if the resident is enrolled in a Minnesota health care program;

(6) date of admission to the facility;

(7) all current diagnoses;

(8) the name of and contact information for the resident's physician or advanced practice registered nurse;

(9) the name and contact information for the resident's responsible party;

(10) the name of and contact information for any case manager, managed care coordinator, or other care coordinator, if known;

(11) information on the resident's status related to commitment and probation; and

(12) the name of the managed care organization in which the resident is enrolled, if known.

Sec. 58. Minnesota Statutes 2018, section 144A.161, subdivision 5a, is amended to read:

Subd. 5a. **Administrator and licensee responsibility to provide notice.** At least 60 days before the proposed date of closing, reduction, or change in operations as agreed to in the plan, the administrator shall send a written notice of closure, reduction, or change in operations to each resident being relocated, the resident's responsible party, the resident's managed care organization if it is known, the county social services agency, the commissioner of health, the commissioner of human services, the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the resident's attending physician or advanced practice registered nurse, and, in the case of a complete facility closure, the Centers for Medicare and Medicaid Services regional office designated representative. The notice must include the following:

(1) the date of the proposed closure, reduction, or change in operations;

(2) the contact information of the individual or individuals in the facility responsible for providing assistance and information;

(3) notification of upcoming meetings for residents, responsible parties, and resident and family councils to discuss the plan for relocation of residents;

(4) the contact information of the county social services agency contact person; and

(5) the contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

Sec. 59. Minnesota Statutes 2018, section 144A.161, subdivision 5e, is amended to read:

Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents desiring to make site visits to facilities with available beds or other appropriate living options to which the resident may relocate, unless it is medically inadvisable, as documented by

the attending physician or advanced practice registered nurse in the resident's care record. The licensee shall make available to the resident at no charge transportation for up to three site visits to facilities or other living options within the county or contiguous counties.

Sec. 60. Minnesota Statutes 2018, section 144A.161, subdivision 5g, is amended to read:

Subd. 5g. **Licensee responsibilities for final written discharge notice and records transfer.** (a) The licensee shall provide the resident, the resident's responsible parties, the resident's managed care organization, if known, and the resident's attending physician or advanced practice registered nurse with a final written discharge notice prior to the relocation of the resident. The notice must:

(1) be provided prior to the actual relocation; and

(2) identify the effective date of the anticipated relocation and the destination to which the resident is being relocated.

(b) The licensee shall provide the receiving facility or other health, housing, or care entity with complete and accurate resident records including contact information for family members, responsible parties, social service or other caseworkers, and managed care coordinators. These records must also include all information necessary to provide appropriate medical care and social services. This includes, but is not limited to, information on preadmission screening, Level I and Level II screening, minimum data set (MDS), all other assessments, current resident diagnoses, social, behavioral, and medication information, required forms, and discharge summaries.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

Sec. 61. Minnesota Statutes 2018, section 144A.75, subdivision 3, is amended to read:

Subd. 3. **Core services.** "Core services" means physician services, registered nursing services, advanced practice registered nurse services, medical social services, and counseling services. A hospice must ensure that at least two core services are regularly provided directly by hospice employees. A hospice provider may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during peak patient loads or under extraordinary circumstances.

Sec. 62. Minnesota Statutes 2018, section 144A.75, subdivision 6, is amended to read:

Subd. 6. **Hospice patient.** "Hospice patient" means an individual whose illness has been documented by the individual's attending physician or advanced practice registered nurse and hospice medical director, who alone or, when unable, through the individual's family has voluntarily consented to and received admission to a hospice provider, and who:

(1) has been diagnosed as terminally ill, with a probable life expectancy of under one year; or

(2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and life-threatening illness contributing to a shortened life expectancy; and is not expected to survive to adulthood.

Sec. 63. Minnesota Statutes 2018, section 144A.752, subdivision 1, is amended to read:

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of hospice providers according to sections 144A.75 to 144A.755. The rules shall include the following:

(1) provisions to ensure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive hospice care;

(2) requirements that hospice providers furnish the commissioner with specified information necessary to implement sections 144A.75 to 144A.755;

(3) standards of training of hospice provider personnel;

(4) standards for medication management, which may vary according to the nature of the hospice care provided, the setting in which the hospice care is provided, or the status of the patient;

(5) standards for hospice patient and hospice patient's family evaluation or assessment, which may vary according to the nature of the hospice care provided or the status of the patient; and

(6) requirements for the involvement of a patient's physician or advanced practice registered nurse; documentation of physicians' or advanced practice registered nurses' orders, if required, and the patient's hospice plan of care; and maintenance of accurate, current clinical records.

Sec. 64. Minnesota Statutes 2018, section 145.853, subdivision 5, is amended to read:

Subd. 5. **Notification; medical care.** A law enforcement officer who determines or has reason to believe that a disabled person is suffering from an illness causing the person's

condition shall promptly notify the person's physician or advanced practice registered nurse, if practicable. If the officer is unable to ascertain the physician's or advanced practice registered nurse's identity or to communicate with the physician or advanced practice registered nurse, the officer shall make a reasonable effort to cause the disabled person to be transported immediately to a medical practitioner or to a facility where medical treatment is available. If the officer believes it unduly dangerous to move the disabled person, the officer shall make a reasonable effort to obtain the assistance of a medical practitioner.

Sec. 65. Minnesota Statutes 2018, section 145.892, subdivision 3, is amended to read:

Subd. 3. **Pregnant woman.** "Pregnant woman" means an individual determined by a licensed physician, advanced practice registered nurse, midwife, or appropriately trained registered nurse to have one or more fetuses in utero.

Sec. 66. Minnesota Statutes 2018, section 145.94, subdivision 2, is amended to read:

Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or to the community, information including data made nonpublic by law, relating to the hazardous properties and health hazards of hazardous substances released from a workplace if the commissioner finds:

(1) evidence that a person requesting the information may have suffered or is likely to suffer illness or injury from exposure to a hazardous substance; or

(2) evidence of a community health risk and if the commissioner seeks to have the employer cease an activity which results in release of a hazardous substance.

Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage according to established standards to prevent unauthorized use or disclosure. If the nonpublic data is required for the diagnosis, treatment, or prevention of illness or injury, a personal physician or advanced practice registered nurse may be provided with this information if the physician or advanced practice registered nurse agrees to preserve the confidentiality of the information, except for patient health records subject to sections 144.291 to 144.298. After the disclosure of any hazardous substance information relating to a particular workplace, the commissioner shall advise the employer of the information disclosed, the date of the disclosure, and the person who received the information.

Sec. 67. Minnesota Statutes 2018, section 145B.13, is amended to read:

145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.

In reliance on a patient's living will, a decision to administer, withhold, or withdraw medical treatment after the patient has been diagnosed by the attending physician or advanced practice registered nurse to be in a terminal condition must always be based on reasonable medical practice, including:

(1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human dignity and to alleviate pain;

(2) oral administration of food or water to a patient who accepts it, except for clearly documented medical reasons; and

(3) in the case of a living will of a patient that the attending physician or advanced practice registered nurse knows is pregnant, the living will must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

Sec. 68. Minnesota Statutes 2018, section 145C.02, is amended to read:

145C.02 HEALTH CARE DIRECTIVE.

A principal with the capacity to do so may execute a health care directive. A health care directive may include one or more health care instructions to direct health care providers, others assisting with health care, family members, and a health care agent. A health care directive may include a health care power of attorney to appoint a health care agent to make health care decisions for the principal when the principal, in the judgment of the principal's attending physician or advanced practice registered nurse, lacks decision-making capacity, unless otherwise specified in the health care directive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) a principal who in good faith does not generally select a physician or advanced practice registered nurse or a health care facility for the principal's health care needs may include a statement appointing an individual who may determine the principal's decision-making capacity, provided that if the need to determine the principal's capacity arises when the principal is receiving care under the direction of an attending physician or advanced practice registered nurse in a health care facility, the determination must be made by an attending physician or advanced practice registered nurse after consultation with the appointed individual.

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

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

Sec. 70. Minnesota Statutes 2018, section 145C.06, is amended to read:

145C.06 WHEN EFFECTIVE.

A health care directive is effective for a health care decision when:

(1) it meets the requirements of section 145C.03, subdivision 1; and

(2) the principal, in the determination of the attending physician or advanced practice registered nurse of the principal, lacks decision-making capacity to make the health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met.

A health care directive is not effective for a health care decision when the principal, in the determination of the attending physician or advanced practice registered nurse of the principal, recovers decision-making capacity; or if other conditions for effectiveness otherwise specified by the principal have been met.

Sec. 71. Minnesota Statutes 2018, section 145C.07, subdivision 1, is amended to read:

Subdivision 1. **Authority.** The health care agent has authority to make any particular health care decision only if the principal lacks decision-making capacity, in the determination of the attending physician or advanced practice registered nurse, to make or communicate that health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met. The physician, advanced practice registered nurse, or other health care provider shall continue to obtain the principal's informed consent to all health care decisions for which the principal has decision-making capacity, unless other conditions for effectiveness otherwise specified by the principal have been met. An alternate health care agent has authority to act if the primary health care agent is not reasonably available to act.

Sec. 72. Minnesota Statutes 2018, section 145C.16, is amended to read:

145C.16 SUGGESTED FORM.

The following is a suggested form of a health care directive and is not a required form.

HEALTH CARE DIRECTIVE

I, ..., understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint ..... to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me:.....

Telephone number of my health care agent:.....

Address of my health care agent:.....

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint ..... to be my health care agent instead.

Relationship of my alternate health care agent to me:.....

Telephone number of my alternate health care agent:.....

Address of my alternate health care agent:.....

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

.....

.....

.....

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

..... (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

..... (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

.....

.....

.....

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:.....

.....

.....

My fears about my health care:.....

.....

.....

My spiritual or religious beliefs and traditions:.....

.....

.....

My beliefs about when life would be no longer worth living:.....

.....

.....

My thoughts about how my medical condition might affect my family:

.....

.....

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:

(Note: You can discuss general feelings, specific treatments, or leave any of them blank)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:.....

.....

.....

If I were dying and unable to decide or speak for myself, I would want:.....

.....

.....

If I were permanently unconscious and unable to decide or speak for myself, I would want:.....

.....

.....

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:.....

.....

.....

In all circumstances, my doctors or advanced practice registered nurses will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:.....

.....

.....

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor or advanced practice registered nurse:.....

.....

.....

Where I would like to live to receive health care:.....

.....

.....

Where I would like to die and other wishes I have about dying:.....

.....

.....

My wishes about donating parts of my body when I die:.....

.....

.....

My wishes about what happens to my body when I die (cremation, burial):.....

.....

.....

Any other things:.....

.....

.....

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

.....

My Signature

Date signed: .....

Date of birth: .....

Address: .....

.....

If I cannot sign my name, I can ask someone to sign this document for me.

.....

Signature of the person who I asked to sign this document for me.

.....

Printed name of the person who I asked to sign this document for me.

Option 1: Notary Public

In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

.....

(Signature of Notary) (Notary Stamp)

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

.....

(Signature of Witness One)

Address: .....

.....

Witness Two:

(i) In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

.....

(Signature of Witness Two)

Address: .....

.....

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors or advanced practice registered nurses, family, close friends, health care agent, and alternate health care agent. Make sure your doctor or advanced practice registered nurse is willing to follow your wishes. This document should be part of your medical record at your physician's or advanced practice registered nurse's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

Sec. 73. Minnesota Statutes 2018, section 148.6438, subdivision 1, is amended to read:

Subdivision 1. **Required notification.** In the absence of a physician or advanced practice registered nurse referral or prior authorization, and before providing occupational therapy services for remuneration or expectation of payment from the client, an occupational therapist must provide the following written notification in all capital letters of 12-point or larger boldface type, to the client, parent, or guardian:

"Your health care provider, insurer, or plan may require a physician or advanced practice registered nurse referral or prior authorization and you may be obligated for partial or full payment for occupational therapy services rendered."

Information other than this notification may be included as long as the notification remains conspicuous on the face of the document. A nonwritten disclosure format may be used to satisfy the recipient notification requirement when necessary to accommodate the physical condition of a client or client's guardian.

Sec. 74. Minnesota Statutes 2018, section 151.19, subdivision 4, is amended to read:

Subd. 4. **Licensing of physicians and advanced practice registered nurses to dispense drugs; renewals.** (a) The board may grant a license to any physician licensed under chapter 147 or advanced practice registered nurse licensed under chapter 148 who provides services in a health care facility located in a designated health professional shortage area authorizing the physician or advanced practice registered nurse to dispense drugs to individuals for whom pharmaceutical care is not reasonably available. The license may be renewed annually. Any physician or advanced practice registered nurse licensed under this subdivision shall be limited to dispensing drugs in a limited service pharmacy and shall be governed by the rules adopted by the board when dispensing drugs.

(b) For the purposes of this subdivision, pharmaceutical care is not reasonably available if the limited service pharmacy in which the physician or advanced practice registered nurse

is dispensing drugs is located in a health professional shortage area, and no other licensed pharmacy is located within 15 miles of the limited service pharmacy.

(c) For the purposes of this subdivision, section 151.15, subdivision 2, shall not apply, and section 151.215 shall not apply provided that a physician or advanced practice registered nurse granted a license under this subdivision certifies each filled prescription in accordance with Minnesota Rules, part 6800.3100, subpart 3.

(d) Notwithstanding section 151.102, a physician or advanced practice registered nurse granted a license under this subdivision may be assisted by a pharmacy technician if the technician holds a valid certification from the Pharmacy Technician Certification Board or from another national certification body for pharmacy technicians that requires passage of a nationally recognized psychometrically valid certification examination for certification as determined by the board. The physician or advanced practice registered nurse may supervise the pharmacy technician as long as the physician or advanced practice registered nurse assumes responsibility for all functions performed by the technician. For purposes of this subdivision, supervision does not require the physician or advanced practice registered nurse to be physically present if the physician, advanced practice registered nurse, or a licensed pharmacist is available, either electronically or by telephone.

(e) Nothing in this subdivision shall be construed to prohibit a physician or advanced practice registered nurse from dispensing drugs pursuant to section 151.37 and Minnesota Rules, parts 6800.9950 to 6800.9954.

Sec. 75. Minnesota Statutes 2018, section 151.21, subdivision 4a, is amended to read:

Subd. 4a. **Sign.** A pharmacy must post a sign in a conspicuous location and in a typeface easily seen at the counter where prescriptions are dispensed stating: "In order to save you money, this pharmacy will substitute whenever possible an FDA-approved, less expensive, generic drug product, which is therapeutically equivalent to and safely interchangeable with the one prescribed by your doctor or advanced practice registered nurse, unless you object to this substitution."

Sec. 76. Minnesota Statutes 2018, section 152.32, subdivision 3, is amended to read:

Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so would violate federal law or regulations or cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ transplants, a registry program enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the equivalent of the authorized use of any other medication used at the discretion of a physician or advanced practice registered nurse and does not constitute the use of an illicit substance or otherwise disqualify a patient from needed medical care.

(c) Unless a failure to do so would violate federal law or regulations or cause an employer to lose a monetary or licensing-related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:

(1) the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37; or

(2) a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, or was impaired by medical cannabis on the premises of the place of employment or during the hours of employment.

(d) An employee who is required to undergo employer drug testing pursuant to section 181.953 may present verification of enrollment in the patient registry as part of the employee's explanation under section 181.953, subdivision 6.

(e) A person shall not be denied custody of a minor child or visitation rights or parenting time with a minor child solely based on the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37. There shall be no presumption of neglect or child endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

Sec. 77. Minnesota Statutes 2018, section 245A.143, subdivision 8, is amended to read:

Subd. 8. **Nutritional services.** (a) The license holder shall ensure that food served is nutritious and meets any special dietary needs of the participants as prescribed by the participant's physician, advanced practice registered nurse, or dietitian as specified in the service delivery plan.

(b) Food and beverages must be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to the health of a resident.

Sec. 78. Minnesota Statutes 2018, section 245A.1435, is amended to read:

245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH IN LICENSED PROGRAMS.

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's physician or advanced practice registered nurse directing an alternative sleeping position for the infant. The physician or advanced practice registered nurse directive must be on a form approved by the commissioner and must remain on file at the licensed location. An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

(b) The license holder must place the infant in a crib directly on a firm mattress with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place anything in the crib with the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title 16, part 1511. The requirements of this section apply to license holders serving infants younger than one year of age. Licensed child care providers must meet the crib requirements under section 245A.146. A correction order shall not be issued under this paragraph unless there is evidence that a violation occurred when an infant was present in the license holder's care.

(c) If an infant falls asleep before being placed in a crib, the license holder must move the infant to a crib as soon as practicable, and must keep the infant within sight of the license holder until the infant is placed in a crib. When an infant falls asleep while being held, the license holder must consider the supervision needs of other children in care when determining how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant must not be in a position where the airway may be blocked or with anything covering the infant's face.

(d) Placing a swaddled infant down to sleep in a licensed setting is not recommended for an infant of any age and is prohibited for any infant who has begun to roll over independently. However, with the written consent of a parent or guardian according to this paragraph, a license holder may place the infant who has not yet begun to roll over on its own down to sleep in a one-piece sleeper equipped with an attached system that fastens

securely only across the upper torso, with no constriction of the hips or legs, to create a swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant on a form provided by the commissioner and prepared in partnership with the Minnesota Sudden Infant Death Center.

Sec. 79. Minnesota Statutes 2018, section 245C.02, subdivision 18, is amended to read:

Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician or advanced practice registered nurse whether or not the care of a physician or advanced practice registered nurse was sought, or abuse resulting in serious injury.

(b) For purposes of this definition, "care of a physician or advanced practice registered nurse" is treatment received or ordered by a physician, physician assistant, advanced practice registered nurse, or nurse practitioner, but does not include:

(1) diagnostic testing, assessment, or observation;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

(d) Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

Sec. 80. Minnesota Statutes 2018, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reapplication for a family child care license:

(1) for a background study affiliated with a licensed family child care center or legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

(d) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

(e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder:

(1) the county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the child foster care applicant or license holder resides in the home where child foster care services are provided;

(2) the child foster care license holder or applicant shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the applicant or license holder does not reside in the home where child foster care services are provided; and

(3) the background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

(f) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B and:

(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a), (b), and (d), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 119B;

(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

(g) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

(h) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(i) For purposes of this section, a physician licensed under chapter 147 or advanced practice registered nurse licensed under chapter 148 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's or advanced practice registered nurse's background study results.

(j) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

(k) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

(l) Before and after school programs authorized under chapter 119B, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.

Sec. 81. Minnesota Statutes 2018, section 245D.02, subdivision 11, is amended to read:

Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to that person, and includes:

(1) serious injury of a person as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician or advanced practice registered nurse treatment, or hospitalization;

(4) any mental health crisis that requires the program to call 911, a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate;

(5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;

(6) a person's unauthorized or unexplained absence from a program;

(7) conduct by a person receiving services against another person receiving services that:

(i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

(ii) places the person in actual and reasonable fear of harm;

(iii) places the person in actual and reasonable fear of damage to property of the person; or

(iv) substantially disrupts the orderly operation of the program;

(8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14;

(9) any emergency use of manual restraint as identified in section 245D.061 or successor provisions; or

(10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Sec. 82. Minnesota Statutes 2018, section 245D.11, subdivision 2, is amended to read:

Subd. 2. **Health and welfare.** The license holder must establish policies and procedures that promote health and welfare by ensuring:

(1) use of universal precautions and sanitary practices in compliance with section 245D.06, subdivision 2, clause (5);

(2) if the license holder operates a residential program, health service coordination and care according to the requirements in section 245D.05, subdivision 1;

(3) safe medication assistance and administration according to the requirements in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in consultation with a registered nurse, ~~nurse practitioner~~ advanced practice registered nurse, physician assistant, or medical doctor and require completion of medication administration training according to the requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance and administration includes, but is not limited to:

(i) providing medication-related services for a person;

(ii) medication setup;

(iii) medication administration;

(iv) medication storage and security;

(v) medication documentation and charting;

(vi) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(vii) coordination of medication refills;

(viii) handling changes to prescriptions and implementation of those changes;

(ix) communicating with the pharmacy; and

(x) coordination and communication with prescriber;

(4) safe transportation, when the license holder is responsible for transportation of persons, with provisions for handling emergency situations according to the requirements in section 245D.06, subdivision 2, clauses (2) to (4);

(5) a plan for ensuring the safety of persons served by the program in emergencies as defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies to the license holder. A license holder with a community residential setting or a day service facility license must ensure the policy and procedures comply with the requirements in section 245D.22, subdivision 4;

(6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11; and reporting all incidents required to be reported according to section 245D.06, subdivision 1. The plan must:

(i) provide the contact information of a source of emergency medical care and transportation; and

(ii) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team or similar mental health response team or service when such a team is available and appropriate when the person is experiencing a mental health crisis; and

(7) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed. The license holder must establish and maintain a record-keeping system for the incident and emergency reports. Each incident and emergency report file must contain a written summary of the incident. The license holder must conduct

a review of incident reports for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. Each incident report must include:

(i) the name of the person or persons involved in the incident. It is not necessary to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident;

(ii) the date, time, and location of the incident or emergency;

(iii) a description of the incident or emergency;

(iv) a description of the response to the incident or emergency and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

(v) the name of the staff person or persons who responded to the incident or emergency; and

(vi) the determination of whether corrective action is necessary based on the results of the review.

Sec. 83. Minnesota Statutes 2018, section 245D.22, subdivision 7, is amended to read:

Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin-operated telephone that is readily accessible. A list of emergency numbers must be posted in a prominent location. When an area has a 911 number or a mental health crisis intervention team number, both numbers must be posted and the emergency number listed must be 911. In areas of the state without a 911 number, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center. The names and telephone numbers of each person's representative, physician or advanced practice registered nurse, and dentist must be readily available.

Sec. 84. Minnesota Statutes 2018, section 245D.25, subdivision 2, is amended to read:

Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed by the person's physician, advanced practice registered nurse, or dietitian. Three nutritionally balanced meals a day must be served or made available to persons, and nutritious snacks must be available between meals.

Sec. 85. Minnesota Statutes 2018, section 245G.08, subdivision 2, is amended to read:

Subd. 2. **Procedures.** The applicant or license holder must have written procedures for obtaining a medical intervention for a client, that are approved in writing by a physician

who is licensed under chapter 147 or advanced practice registered nurse who is licensed under chapter 148, unless:

(1) the license holder does not provide a service under section 245G.21; and

(2) a medical intervention is referred to 911, the emergency telephone number, or the client's physician or advanced practice registered nurse.

Sec. 86. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended to read:

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

Sec. 87. Minnesota Statutes 2018, section 245G.08, subdivision 5, is amended to read:

Subd. 5. **Administration of medication and assistance with self-medication.** (a) A license holder must meet the requirements in this subdivision if a service provided includes the administration of medication.

(b) A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assisting with self-medication, must:

(1) successfully complete a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. A staff member's completion of the course must be documented in writing and placed in the staff member's personnel file;

(2) be trained according to a formalized training program that is taught by a registered nurse and offered by the license holder. The training must include the process for administration of naloxone, if naloxone is kept on site. A staff member's completion of the training must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity. A registered nurse must be employed or contracted to develop the policies and procedures for administration of medication or assisting with self-administration of medication, or both.

(c) A registered nurse must provide supervision as defined in section 148.171, subdivision 23. The registered nurse's supervision must include, at a minimum, monthly on-site supervision or more often if warranted by a client's health needs. The policies and procedures must include:

(1) a provision that a delegation of administration of medication is limited to the administration of a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, or an inhalant;

(2) a provision that each client's file must include documentation indicating whether staff must conduct the administration of medication or the client must self-administer medication, or both;

(3) a provision that a client may carry emergency medication such as nitroglycerin as instructed by the client's physician or advanced practice registered nurse;

(4) a provision for the client to self-administer medication when a client is scheduled to be away from the facility;

(5) a provision that if a client self-administers medication when the client is present in the facility, the client must self-administer medication under the observation of a trained staff member;

(6) a provision that when a license holder serves a client who is a parent with a child, the parent may only administer medication to the child under a staff member's supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a nurse of problems with self-administration of medication, including a client's failure to administer, refusal of a medication, adverse reaction, or error; and

(9) procedures for acceptance, documentation, and implementation of a prescription, whether written, verbal, telephonic, or electronic.

Sec. 88. Minnesota Statutes 2018, section 245G.21, subdivision 2, is amended to read:

Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours,

including both day and evening times. A client's right to receive visitors other than a personal physician or advanced practice registered nurse, religious adviser, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided the limitation and the reasons for the limitation are documented in the client's file. A client must be allowed to receive visits at all reasonable times from the client's personal physician or advanced practice registered nurse, religious adviser, county case manager, parole or probation officer, and attorney.

Sec. 89. Minnesota Statutes 2018, section 245G.21, subdivision 3, is amended to read:

Subd. 3. **Client property management.** A license holder who provides room and board and treatment services to a client in the same facility, and any license holder that accepts client property must meet the requirements for handling client funds and property in section 245A.04, subdivision 13. License holders:

(1) may establish policies regarding the use of personal property to ensure that treatment activities and the rights of other clients are not infringed upon;

(2) may take temporary custody of a client's property for violation of a facility policy;

(3) must retain the client's property for a minimum of seven days after the client's service termination if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

(4) must return all property held in trust to the client at service termination regardless of the client's service termination status, except that:

(i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section 609.5316, must be given to the custody of a local law enforcement agency. If giving the property to the custody of a local law enforcement agency violates Code of Federal Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug paraphernalia, or drug container must be destroyed by a staff member designated by the program director; and

(ii) a weapon, explosive, and other property that can cause serious harm to the client or others must be given to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the client's right to reclaim any lawful property transferred; and

(iii) a medication that was determined by a physician or advanced practice registered nurse to be harmful after examining the client must be destroyed, except when the client's personal physician or advanced practice registered nurse approves the medication for continued use.

Sec. 90. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

245H.11 REPORTING.

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

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

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

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

Sec. 91. Minnesota Statutes 2018, section 246.711, subdivision 2, is amended to read:

Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections 246.71 to 246.722 when all of the following conditions are met:

(1) a licensed physician or advanced practice registered nurse determines that a significant exposure has occurred following the protocol under section 246.721;

(2) the licensed physician or advanced practice registered nurse for the employee needs the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue treatment in accordance with the most current guidelines of the United States Public Health Service, because of possible exposure to a blood-borne pathogen; and

(3) the employee consents to providing a blood sample for testing for a blood-borne pathogen.

Sec. 92. Minnesota Statutes 2018, section 246.715, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but does not consent to blood-borne pathogens testing, the secure treatment facility shall ensure that the blood is tested for blood-borne pathogens if the employee requests the test, provided all of the following criteria are met:

(1) the employee and secure treatment facility have documented exposure to blood or body fluids during performance of the employee's work duties;

(2) a licensed physician or advanced practice registered nurse has determined that a significant exposure has occurred under section 246.711 and has documented that blood-borne pathogen test results are needed for beginning, modifying, continuing, or discontinuing medical treatment for the employee as recommended by the most current guidelines of the United States Public Health Service;

(3) the employee provides a blood sample for testing for blood-borne pathogens as soon as feasible;

(4) the secure treatment facility asks the patient to consent to a test for blood-borne pathogens and the patient does not consent;

(5) the secure treatment facility has provided the patient and the employee with all of the information required by section 246.712; and

(6) the secure treatment facility has informed the employee of the confidentiality requirements of section 246.719 and the penalties for unauthorized release of patient information under section 246.72.

Sec. 93. Minnesota Statutes 2018, section 246.716, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** (a) A secure treatment facility or an employee of a secure treatment facility may bring a petition for a court order to require a patient to provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in the district court in the county where the patient is receiving treatment from the secure treatment facility. The secure treatment facility shall serve the petition on the patient three days before a hearing on the petition. The petition shall include one or more affidavits attesting that:

(1) the secure treatment facility followed the procedures in sections 246.71 to 246.722 and attempted to obtain blood-borne pathogen test results according to those sections;

(2) a licensed physician or advanced practice registered nurse knowledgeable about the most current recommendations of the United States Public Health Service has determined that a significant exposure has occurred to the employee of a secure treatment facility under section 246.721; and

(3) a physician or advanced practice registered nurse has documented that the employee has provided a blood sample and consented to testing for blood-borne pathogens and

blood-borne pathogen test results are needed for beginning, continuing, modifying, or discontinuing medical treatment for the employee under section 246.721.

(b) Facilities shall cooperate with petitioners in providing any necessary affidavits to the extent that facility staff can attest under oath to the facts in the affidavits.

(c) The court may order the patient to provide a blood sample for blood-borne pathogen testing if:

(1) there is probable cause to believe the employee of a secure treatment facility has experienced a significant exposure to the patient;

(2) the court imposes appropriate safeguards against unauthorized disclosure that must specify the persons who have access to the test results and the purposes for which the test results may be used;

(3) a licensed physician or advanced practice registered nurse for the employee of a secure treatment facility needs the test results for beginning, continuing, modifying, or discontinuing medical treatment for the employee; and

(4) the court finds a compelling need for the test results. In assessing compelling need, the court shall weigh the need for the court-ordered blood collection and test results against the interests of the patient, including, but not limited to, privacy, health, safety, or economic interests. The court shall also consider whether involuntary blood collection and testing would serve the public interests.

(d) The court shall conduct the proceeding in camera unless the petitioner or the patient requests a hearing in open court and the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) The patient may arrange for counsel in any proceeding brought under this subdivision.

Sec. 94. Minnesota Statutes 2018, section 246.721, is amended to read:

246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.

(a) A secure treatment facility shall follow applicable Occupational Safety and Health Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for blood-borne pathogens.

(b) Every secure treatment facility shall adopt and follow a postexposure protocol for employees at a secure treatment facility who have experienced a significant exposure. The postexposure protocol must adhere to the most current recommendations of the United States Public Health Service and include, at a minimum, the following:

(1) a process for employees to report an exposure in a timely fashion;

(2) a process for an infectious disease specialist, or a licensed physician or advanced practice registered nurse who is knowledgeable about the most current recommendations of the United States Public Health Service in consultation with an infectious disease specialist, (i) to determine whether a significant exposure to one or more blood-borne pathogens has occurred, and (ii) to provide, under the direction of a licensed physician or advanced practice registered nurse, a recommendation or recommendations for follow-up treatment appropriate to the particular blood-borne pathogen or pathogens for which a significant exposure has been determined;

(3) if there has been a significant exposure, a process to determine whether the patient has a blood-borne pathogen through disclosure of test results, or through blood collection and testing as required by sections 246.71 to 246.722;

(4) a process for providing appropriate counseling prior to and following testing for a blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and follow-up recommendations according to the most current recommendations of the United States Public Health Service, recommendations for testing, and treatment;

(5) a process for providing appropriate counseling under clause (4) to the employee of a secure treatment facility and to the patient; and

(6) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights.

Sec. 95. Minnesota Statutes 2018, section 246.722, is amended to read:

246.722 IMMUNITY.

A secure treatment facility, licensed physician or advanced practice registered nurse, and designated health care personnel are immune from liability in any civil, administrative, or criminal action relating to the disclosure of test results of a patient to an employee of a secure treatment facility and the testing of a blood sample from the patient for blood-borne pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

Sec. 96. Minnesota Statutes 2018, section 251.043, subdivision 1, is amended to read:

Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in the preceding section, the workers' compensation division finds that an employee is suffering from tuberculosis contracted in the institution or department by contact with inmates or patients therein or by contact with tuberculosis contaminated material therein, it shall order the

employee to seek the services of a physician, advanced practice registered nurse, or medical care facility. There shall be paid to the physician, advanced practice registered nurse, or facility where the employee may be received, the same fee for the maintenance and care of the person as is received by the institution for the maintenance and care of a nonresident patient. If the employee worked in a state hospital or nursing home, payment for the care shall be made by the commissioner of human services. If employed in any other institution or department the payment shall be made from funds allocated or appropriated for the operation of the institution or department. If the employee dies from the effects of the disease of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of death, the workers' compensation division shall order payment to dependents as provided for under the general provisions of the workers' compensation law.

Sec. 97. Minnesota Statutes 2018, section 252A.02, subdivision 12, is amended to read:

Subd. 12. **Comprehensive evaluation.** "Comprehensive evaluation" shall consist of:

(1) a medical report on the health status and physical condition of the proposed ward, prepared under the direction of a licensed physician or advanced practice registered nurse;

(2) a report on the proposed ward's intellectual capacity and functional abilities, specifying the tests and other data used in reaching its conclusions, prepared by a psychologist who is qualified in the diagnosis of developmental disability; and

(3) a report from the case manager that includes:

(i) the most current assessment of individual service needs as described in rules of the commissioner;

(ii) the most current individual service plan under section 256B.092, subdivision 1b; and

(iii) a description of contacts with and responses of near relatives of the proposed ward notifying them that a nomination for public guardianship has been made and advising them that they may seek private guardianship.

Each report shall contain recommendations as to the amount of assistance and supervision required by the proposed ward to function as independently as possible in society. To be considered part of the comprehensive evaluation, reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 98. Minnesota Statutes 2018, section 252A.04, subdivision 2, is amended to read:

Subd. 2. **Medication; treatment.** A proposed ward who, at the time the comprehensive evaluation is to be performed, has been under medical care shall not be so under the influence or so suffer the effects of drugs, medication, or other treatment as to be hampered in the testing or evaluation process. When in the opinion of the licensed physician or advanced practice registered nurse attending the proposed ward, the discontinuance of medication or other treatment is not in the proposed ward's best interest, the physician or advanced practice registered nurse shall record a list of all drugs, medication or other treatment which the proposed ward received 48 hours immediately prior to any examination, test or interview conducted in preparation for the comprehensive evaluation.

Sec. 99. Minnesota Statutes 2018, section 252A.20, subdivision 1, is amended to read:

Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each physician, advanced practice registered nurse, psychologist, or social worker who assists in the preparation of the comprehensive evaluation and who is not in the employ of the local agency or the state Department of Human Services, a reasonable sum for services and for travel; and to the ward's counsel, when appointed by the court, a reasonable sum for travel and for each day or portion of a day actually employed in court or actually consumed in preparing for the hearing. Upon order the county auditor shall issue a warrant on the county treasurer for payment of the amount allowed.

Sec. 100. Minnesota Statutes 2018, section 253B.03, subdivision 4, is amended to read:

Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a personal physician or advanced practice registered nurse, spiritual advisor, and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Sec. 101. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

Subd. 6d. **Adult mental health treatment.** (a) A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) A declaration is effective only if it is signed by the declarant and two witnesses. The witnesses must include a statement that they believe the declarant understands the nature and significance of the declaration. A declaration becomes operative when it is delivered to the declarant's physician, advanced practice registered nurse, or other mental health treatment provider. The physician, advanced practice registered nurse, or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician, advanced practice registered nurse, or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent. A treatment provider may not require a person to make a declaration under this subdivision as a condition of receiving services.

(d) The physician, advanced practice registered nurse, or other provider shall make the declaration a part of the declarant's medical record. If the physician, advanced practice registered nurse, or other provider is unwilling at any time to comply with the declaration, the physician, advanced practice registered nurse, or provider must promptly notify the declarant and document the notification in the declarant's medical record. If the declarant has been committed as a patient under this chapter, the physician, advanced practice registered nurse, or provider may subject a declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only upon order of the committing court. If the declarant is not a committed patient under this chapter, the physician, advanced practice registered nurse, or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as mentally ill or mentally ill and dangerous to the public and a court order authorizing the treatment has been issued.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation. A revocation is effective when a competent declarant communicates the revocation to the attending physician, advanced practice registered nurse, or other provider. The attending physician, advanced practice registered nurse, or other provider shall note the revocation as part of the declarant's medical record.

(f) A provider who administers intrusive mental health treatment according to and in good faith reliance upon the validity of a declaration under this subdivision is held harmless from any liability resulting from a subsequent finding of invalidity.

(g) In addition to making a declaration under this subdivision, a competent adult may delegate parental powers under section 524.5-211 or may nominate a guardian under sections 524.5-101 to 524.5-502.

Sec. 102. Minnesota Statutes 2018, section 253B.06, subdivision 1, is amended to read:

Subdivision 1. **Persons who are mentally ill or developmentally disabled.** Every patient hospitalized as mentally ill or developmentally disabled pursuant to section 253B.04 or 253B.05 must be examined by a physician or advanced practice registered nurse as soon as possible but no more than 48 hours following admission. The physician or advanced practice registered nurse shall be knowledgeable and trained in the diagnosis of the alleged disability related to the need for admission as a person who is mentally ill or developmentally disabled.

Sec. 103. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

Subd. 2. **Chemically dependent persons.** Patients hospitalized as chemically dependent pursuant to section 253B.04 or 253B.05 shall also be examined within 48 hours of admission. At a minimum, the examination shall consist of a physical evaluation by facility staff according to procedures established by a physician or advanced practice registered nurse and an evaluation by staff knowledgeable and trained in the diagnosis of the alleged disability related to the need for admission as a chemically dependent person.

Sec. 104. Minnesota Statutes 2018, section 253B.07, subdivision 2, is amended to read:

Subd. 2. **The petition.** (a) Any interested person, except a member of the prepetition screening team, may file a petition for commitment in the district court of the county of financial responsibility or the county where the proposed patient is present. If the head of the treatment facility believes that commitment is required and no petition has been filed, the head of the treatment facility shall petition for the commitment of the person.

(b) The petition shall set forth the name and address of the proposed patient, the name and address of the patient's nearest relatives, and the reasons for the petition. The petition must contain factual descriptions of the proposed patient's recent behavior, including a description of the behavior, where it occurred, and the time period over which it occurred. Each factual allegation must be supported by observations of witnesses named in the petition. Petitions shall be stated in behavioral terms and shall not contain judgmental or conclusory statements.

(c) The petition shall be accompanied by a written statement by an examiner stating that the examiner has examined the proposed patient within the 15 days preceding the filing of the petition and is of the opinion that the proposed patient is suffering a designated disability and should be committed to a treatment facility. The statement shall include the reasons for the opinion. In the case of a commitment based on mental illness, the petition and the examiner's statement shall include, to the extent this information is available, a statement and opinion regarding the proposed patient's need for treatment with neuroleptic medication and the patient's capacity to make decisions regarding the administration of neuroleptic medications, and the reasons for the opinion. If use of neuroleptic medications is recommended by the treating physician or advanced practice registered nurse, the petition for commitment must, if applicable, include or be accompanied by a request for proceedings under section 253B.092. Failure to include the required information regarding neuroleptic medications in the examiner's statement, or to include a request for an order regarding neuroleptic medications with the commitment petition, is not a basis for dismissing the commitment petition. If a petitioner has been unable to secure a statement from an examiner, the petition shall include documentation that a reasonable effort has been made to secure the supporting statement.

Sec. 105. Minnesota Statutes 2018, section 253B.08, subdivision 5, is amended to read:

Subd. 5. **Absence permitted.** (a) The court may permit the proposed patient to waive the right to attend the hearing if it determines that the waiver is freely given. At the time of the hearing the patient shall not be so under the influence of drugs, medication, or other treatment so as to be hampered in participating in the proceedings. When the licensed physician, licensed advanced practice registered nurse, or licensed psychologist attending the patient is of the opinion that the discontinuance of drugs, medication, or other treatment is not in the best interest of the patient, the court, at the time of the hearing, shall be presented a record of all drugs, medication or other treatment which the patient has received during the 48 hours immediately prior to the hearing.

(b) The court, on its own motion or on the motion of any party, may exclude or excuse a proposed patient who is seriously disruptive or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the proposed patient or other circumstances justifying proceeding in the absence of the proposed patient.

Sec. 106. Minnesota Statutes 2018, section 253B.092, subdivision 2, is amended to read:

Subd. 2. **Administration without judicial review.** Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care directive under chapter 145C or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) the patient has been prescribed neuroleptic medication prior to admission to a treatment facility, but lacks the capacity to consent to the administration of that neuroleptic medication; continued administration of the medication is in the patient's best interest; and the patient does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating physician or advanced practice registered nurse:

(i) is obtaining a substitute decision-maker appointed by the court under subdivision 6; or

(ii) is requesting an amendment to a current court order authorizing administration of neuroleptic medication;

(4) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

(5) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

Sec. 107. Minnesota Statutes 2018, section 253B.092, subdivision 3, is amended to read:

Subd. 3. **Emergency administration.** A treating physician or advanced practice registered nurse may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating physician or advanced practice registered nurse determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating physician or advanced practice registered nurse may continue

the medication through the date of the first court hearing, if the emergency continues to exist. If the request for authorization to administer medication is made to the court in conjunction with a petition for commitment or early intervention and the court makes a determination at the preliminary hearing under section 253B.07, subdivision 7, that there is sufficient cause to continue the physician's or advanced practice registered nurse's order until the hearing under section 253B.08, the treating physician or advanced practice registered nurse may continue the medication until that hearing, if the emergency continues to exist. The treatment facility shall document the emergency in the patient's medical record in specific behavioral terms.

Sec. 108. Minnesota Statutes 2018, section 253B.092, subdivision 6, is amended to read:

Subd. 6. **Patients without capacity to make informed decision; substitute decision-maker.** (a) Upon request of any person, and upon a showing that administration of neuroleptic medications may be recommended and that the person may lack capacity to make decisions regarding the administration of neuroleptic medication, the court shall appoint a substitute decision-maker with authority to consent to the administration of neuroleptic medication as provided in this section. A hearing is not required for an appointment under this paragraph. The substitute decision-maker must be an individual or a community or institutional multidisciplinary panel designated by the local mental health authority. In appointing a substitute decision-maker, the court shall give preference to a guardian or conservator, proxy, or health care agent with authority to make health care decisions for the patient. The court may provide for the payment of a reasonable fee to the substitute decision-maker for services under this section or may appoint a volunteer.

(b) If the person's treating physician or advanced practice registered nurse recommends treatment with neuroleptic medication, the substitute decision-maker may give or withhold consent to the administration of the medication, based on the standards under subdivision 7. If the substitute decision-maker gives informed consent to the treatment and the person does not refuse, the substitute decision-maker shall provide written consent to the treating physician or advanced practice registered nurse and the medication may be administered. The substitute decision-maker shall also notify the court that consent has been given. If the substitute decision-maker refuses or withdraws consent or the person refuses the medication, neuroleptic medication may not be administered to the person without a court order or in an emergency.

(c) A substitute decision-maker appointed under this section has access to the relevant sections of the patient's health records on the past or present administration of medication.

The designated agency or a person involved in the patient's physical or mental health care may disclose information to the substitute decision-maker for the sole purpose of performing the responsibilities under this section. The substitute decision-maker may not disclose health records obtained under this paragraph except to the extent necessary to carry out the duties under this section.

(d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity by a preponderance of the evidence. If a substitute decision-maker has been appointed by the court, the court shall make findings regarding the patient's capacity to make decisions regarding the administration of neuroleptic medications and affirm or reverse its appointment of a substitute decision-maker. If the court affirms the appointment of the substitute decision-maker, and if the substitute decision-maker has consented to the administration of the medication and the patient has not refused, the court shall make findings that the substitute decision-maker has consented and the treatment is authorized. If a substitute decision-maker has not yet been appointed, upon request the court shall make findings regarding the patient's capacity and appoint a substitute decision-maker if appropriate.

(e) If an order for civil commitment or early intervention did not provide for the appointment of a substitute decision-maker or for the administration of neuroleptic medication, the treatment facility may later request the appointment of a substitute decision-maker upon a showing that administration of neuroleptic medications is recommended and that the person lacks capacity to make decisions regarding the administration of neuroleptic medications. A hearing is not required in order to administer the neuroleptic medication unless requested under subdivision 10 or if the substitute decision-maker withholds or refuses consent or the person refuses the medication.

(f) The substitute decision-maker's authority to consent to treatment lasts for the duration of the court's order of appointment or until modified by the court.

If the substitute decision-maker withdraws consent or the patient refuses consent, neuroleptic medication may not be administered without a court order.

(g) If there is no hearing after the preliminary hearing, then the court shall, upon the request of any interested party, review the reasonableness of the substitute decision-maker's decision based on the standards under subdivision 7. The court shall enter an order upholding or reversing the decision within seven days.

Sec. 109. Minnesota Statutes 2018, section 253B.092, subdivision 8, is amended to read:

Subd. 8. **Procedure when patient refuses medication.** (a) If the substitute decision-maker or the patient refuses to consent to treatment with neuroleptic medications, and absent an emergency as set forth in subdivision 3, neuroleptic medications may not be administered without a court order. Upon receiving a written request for a hearing, the court shall schedule the hearing within 14 days of the request. The matter may be heard as part of any other district court proceeding under this chapter. By agreement of the parties or for good cause shown, the court may extend the time of hearing an additional 30 days.

(b) The patient must be examined by a court examiner prior to the hearing. If the patient refuses to participate in an examination, the examiner may rely on the patient's medical records to reach an opinion as to the appropriateness of neuroleptic medication. The patient is entitled to counsel and a second examiner, if requested by the patient or patient's counsel.

(c) The court may base its decision on relevant and admissible evidence, including the testimony of a treating physician or advanced practice registered nurse or other qualified physician, a member of the patient's treatment team, a court-appointed examiner, witness testimony, or the patient's medical records.

(d) If the court finds that the patient has the capacity to decide whether to take neuroleptic medication or that the patient lacks capacity to decide and the standards for making a decision to administer the medications under subdivision 7 are not met, the treating facility may not administer medication without the patient's informed written consent or without the declaration of an emergency, or until further review by the court.

(e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic medication and has applied the standards set forth in subdivision 7, the court may authorize the treating facility and any other community or treatment facility to which the patient may be transferred or provisionally discharged, to involuntarily administer the medication to the patient. A copy of the order must be given to the patient, the patient's attorney, the county attorney, and the treatment facility. The treatment facility may not begin administration of the neuroleptic medication until it notifies the patient of the court's order authorizing the treatment.

(f) A finding of lack of capacity under this section must not be construed to determine the patient's competence for any other purpose.

(g) The court may authorize the administration of neuroleptic medication until the termination of a determinate commitment. If the patient is committed for an indeterminate period, the court may authorize treatment of neuroleptic medication for not more than two

years, subject to the patient's right to petition the court for review of the order. The treatment facility must submit annual reports to the court, which shall provide copies to the patient and the respective attorneys.

(h) The court may limit the maximum dosage of neuroleptic medication that may be administered.

(i) If physical force is required to administer the neuroleptic medication, force may only take place in a treatment facility or therapeutic setting where the person's condition can be reassessed and appropriate medical staff are available.

Sec. 110. Minnesota Statutes 2018, section 253B.0921, is amended to read:

253B.0921 ACCESS TO MEDICAL RECORDS.

A treating physician or advanced practice registered nurse who makes medical decisions regarding the prescription and administration of medication for treatment of a mental illness has access to the relevant sections of a patient's health records on past administration of medication at any treatment facility, if the patient lacks the capacity to authorize the release of records. Upon request of a treating physician or advanced practice registered nurse under this section, a treatment facility shall supply complete information relating to the past records on administration of medication of a patient subject to this chapter. A patient who has the capacity to authorize the release of data retains the right to make decisions regarding access to medical records as provided by sections 144.291 to 144.298.

Sec. 111. Minnesota Statutes 2018, section 253B.20, subdivision 4, is amended to read:

Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of any committed person, the designated agency of the county of financial responsibility, in cooperation with the head of the treatment facility, and the patient's physician or advanced practice registered nurse, if notified pursuant to subdivision 6, shall establish a continuing plan of aftercare services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in the patient's readjustment to the community.

Sec. 112. Minnesota Statutes 2018, section 253B.20, subdivision 6, is amended to read:

Subd. 6. **Notice to physician or advanced practice registered nurse.** The head of the treatment facility shall notify the physician or advanced practice registered nurse of any

committed person at the time of the patient's discharge or provisional discharge, unless the patient objects to the notice.

Sec. 113. Minnesota Statutes 2018, section 253B.23, subdivision 4, is amended to read:

Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege otherwise existing between patient and physician, patient and advanced practice registered nurse, patient and psychologist, patient and examiner, or patient and social worker, is waived as to any physician, advanced practice registered nurse, psychologist, examiner, or social worker who provides information with respect to a patient pursuant to any provision of this chapter.

Sec. 114. Minnesota Statutes 2018, section 254A.08, subdivision 2, is amended to read:

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the Department of Human Services under chapter 245A, and governed by the standards of Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of substance misuse or substance use disorder and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician or advanced practice registered nurse for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

Sec. 115. Minnesota Statutes 2018, section 256.9685, subdivision 1c, is amended to read:

Subd. 1c. **Judicial review.** A hospital ~~or~~, physician, or advanced practice registered nurse aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician, advanced practice registered nurse, or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Sec. 116. Minnesota Statutes 2018, section 256.975, subdivision 7a, is amended to read:

Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a) All individuals seeking admission to Medicaid-certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the need for nursing facility level of care as described in section 256B.0911, subdivision 4e, and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

(c) The following criteria apply to the preadmission screening:

(1) requests for preadmission screenings must be submitted via an online form developed by the commissioner;

(2) the Senior LinkAge Line must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(3) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(d) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(e) In assessing a person's needs, the screener shall:

(1) use an automated system designated by the commissioner;

(2) consult with care transitions coordinators ~~or~~, physician, or advanced practice registered nurse; and

(3) consider the assessment of the individual's physician or advanced practice registered nurse.

Other personnel may be included in the level of care determination as deemed necessary by the screener.

Sec. 117. Minnesota Statutes 2018, section 256.975, subdivision 11, is amended to read:

Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging shall award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

(b) The project areas for grants include:

(1) local or community-based initiatives to promote the benefits of physician or advanced practice registered nurse consultations for all individuals who suspect a memory or cognitive problem;

(2) local or community-based initiatives to promote the benefits of early diagnosis of Alzheimer's disease and other dementias; and

(3) local or community-based initiatives to provide informational materials and other resources to caregivers of persons with dementia.

(c) Eligible applicants for local and regional grants may include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations.

(d) Applicants must:

(1) describe the proposed initiative, including the targeted community and how the initiative meets the requirements of this subdivision; and

(2) identify the proposed outcomes of the initiative and the evaluation process to be used to measure these outcomes.

(e) In awarding the regional and local dementia grants, the Minnesota Board on Aging must give priority to applicants who demonstrate that the proposed project:

(1) is supported by and appropriately targeted to the community the applicant serves;

(2) is designed to coordinate with other community activities related to other health initiatives, particularly those initiatives targeted at the elderly;

(3) is conducted by an applicant able to demonstrate expertise in the project areas;

(4) utilizes and enhances existing activities and resources or involves innovative approaches to achieve success in the project areas; and

(5) strengthens community relationships and partnerships in order to achieve the project areas.

(f) The board shall divide the state into specific geographic regions and allocate a percentage of the money available for the local and regional dementia grants to projects or initiatives aimed at each geographic region.

(g) The board shall award any available grants by January 1, 2016, and each July 1 thereafter.

(h) Each grant recipient shall report to the board on the progress of the initiative at least once during the grant period, and within two months of the end of the grant period shall submit a final report to the board that includes the outcome results.

(i) The Minnesota Board on Aging shall:

(1) develop the criteria and procedures to allocate the grants under this subdivision, evaluate all applicants on a competitive basis and award the grants, and select qualified

providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training; and

(2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on the dementia grants programs under this subdivision to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over health finance and policy. The report shall include:

(i) information on each grant recipient;

(ii) a summary of all projects or initiatives undertaken with each grant;

(iii) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation; and

(iv) an accounting of how the grant funds were spent.

Sec. 118. Minnesota Statutes 2018, section 256B.04, subdivision 14a, is amended to read:

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician assistant, ~~a nurse practitioner~~ an advanced practice registered nurse, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than annually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

Sec. 119. Minnesota Statutes 2018, section 256B.043, subdivision 2, is amended to read:

Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part of their ongoing duties, shall consider the adequacy of the current system of community health clinics and centers both statewide and in urban areas with significant disparities in health status and access to services across racial and ethnic groups, including:

(1) methods to provide 24-hour availability of care through the clinics and centers;

(2) methods to expand the availability of care through the clinics and centers;

(3) the use of grants to expand the number of clinics and centers, the services provided, and the availability of care; and

(4) the extent to which increased use of physician assistants, ~~nurse practitioners~~ advanced practice registered nurses, medical residents and interns, and other allied health professionals in clinics and centers would increase the availability of services.

(b) The commissioners shall make departmental modifications and legislative recommendations as appropriate on the basis of their considerations under paragraph (a).

Sec. 120. Minnesota Statutes 2018, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an

undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians or advanced practice registered nurse or advanced practice registered nurses, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Sec. 121. Minnesota Statutes 2018, section 256B.0622, subdivision 2b, is amended to read:

Subd. 2b. **Continuing stay and discharge criteria for assertive community treatment.** (a) A client receiving assertive community treatment is eligible to continue receiving services if:

(1) the client has not achieved the desired outcomes of their individual treatment plan;

(2) the client's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(3) the client continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; or

(4) the client is functioning effectively with this service and discharge would otherwise be indicated but without continued services the client's functioning would decline; and

(5) one of the following must also apply:

(i) the client has achieved current individual treatment plan goals but additional goals are indicated as evidenced by documented symptoms;

(ii) the client is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the individual treatment plan;

(iii) the client is making progress, but the specific interventions in the individual treatment plan need to be modified so that greater gains, which are consistent with the client's potential level of functioning, are possible; or

(iv) the client fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the individual treatment plan.

(b) Clients receiving assertive community treatment are eligible to be discharged if they meet at least one of the following criteria:

(1) the client and the ACT team determine that assertive community treatment services are no longer needed based on the attainment of goals as identified in the individual treatment plan and a less intensive level of care would adequately address current goals;

(2) the client moves out of the ACT team's service area and the ACT team has facilitated the referral to either a new ACT team or other appropriate mental health service and has assisted the individual in the transition process;

(3) the client, or the client's legal guardian when applicable, chooses to withdraw from assertive community treatment services and documented attempts by the ACT team to re-engage the client with the service have not been successful;

(4) the client has a demonstrated need for a medical nursing home placement lasting more than three months, as determined by a physician or advanced practice registered nurse;

(5) the client is hospitalized, in residential treatment, or in jail for a period of greater than three months. However, the ACT team must make provisions for the client to return to the ACT team upon their discharge or release from the hospital or jail if the client still meets eligibility criteria for assertive community treatment and the team is not at full capacity;

(6) the ACT team is unable to locate, contact, and engage the client for a period of greater than three months after persistent efforts by the ACT team to locate the client; or

(7) the client requests a discharge, despite repeated and proactive efforts by the ACT team to engage the client in service planning. The ACT team must develop a transition plan to arrange for alternate treatment for clients in this situation who have a history of suicide attempts, assault, or forensic involvement.

(c) For all clients who are discharged from assertive community treatment to another service provider within the ACT team's service area there is a three-month transfer period, from the date of discharge, during which a client who does not adjust well to the new service, may voluntarily return to the ACT team. During this period, the ACT team must maintain contact with the client's new service provider.

Sec. 122. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting

and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 123. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to read:

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

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

Sec. 124. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or ~~a nurse practitioner~~ an advanced practice registered nurse employed by or under contract with a community health

board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

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

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

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

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

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

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

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and

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

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

Sec. 125. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

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

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30

and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

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

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

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

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

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

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

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

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

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

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

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

(g) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, or a medical or mental health professional to certify that the

recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

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

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

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

(i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

(k) The commissioner shall:

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

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

(3) investigate all complaints and appeals.

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

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

(1) $0.22 per mile for client reimbursement;

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 126. Minnesota Statutes 2018, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary in making a determination for eligibility for individualized education program and

individualized family service plan services and for medical services identified in a recipient's individualized education program and individualized family service plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individualized education program be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's or advanced practice registered nurse's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individualized education program are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individualized education program does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician or advanced practice registered nurse review and approval of the plan not more than once annually or upon any modification of the individualized education program that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Professional Educator Licensing and Standards Board as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individualized education program or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Sec. 127. Minnesota Statutes 2018, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. ~~**Certified nurse practitioner**~~ **Advanced practice registered nurse services.** Medical assistance covers services performed by a certified pediatric ~~nurse practitioner~~ advanced practice registered nurse, a certified family ~~nurse practitioner~~ advanced practice registered nurse, a certified adult ~~nurse practitioner~~ advanced practice registered

nurse, a certified obstetric/gynecological ~~nurse practitioner~~ advanced practice registered nurse, a certified neonatal ~~nurse practitioner~~ advanced practice registered nurse, or a certified geriatric ~~nurse practitioner~~ advanced practice registered nurse in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the ~~nurse practitioner's~~ advanced practice registered nurse's license as a registered nurse, as defined in section 148.171.

Sec. 128. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is amended to read:

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

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

(1) verbal or visual reminders of discharge orders;

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

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

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

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

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

Sec. 129. Minnesota Statutes 2018, section 256B.0654, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing services provided to recipients who meet the criteria for regular home care nursing and require life-sustaining interventions to reduce the risk of long-term injury or death.

(b) "Home care nursing" means ongoing ~~physician-ordered~~ hourly nursing ordered by a physician or advanced practice registered nurse and services performed by a registered nurse or licensed practical nurse within the scope of practice as defined by the Minnesota Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a person's health.

(c) "Home care nursing agency" means a medical assistance enrolled provider licensed under chapter 144A to provide home care nursing services.

(d) "Regular home care nursing" means home care nursing provided because:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(e) "Shared home care nursing" means the provision of home care nursing services by a home care nurse to two recipients at the same time and in the same setting.

Sec. 130. Minnesota Statutes 2018, section 256B.0654, subdivision 2a, is amended to read:

Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

(1) in the recipient's home or outside the home when normal life activities require;

(2) when the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; and

(3) when the care required is outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) Home care nursing services must be:

(1) assessed by a registered nurse on a form approved by the commissioner;

(2) ordered by a physician or advanced practice registered nurse and documented in a plan of care that is reviewed by the physician at least once every 60 days; and

(3) authorized by the commissioner under section 256B.0652.

Sec. 131. Minnesota Statutes 2018, section 256B.0654, subdivision 3, is amended to read:

Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared home care nursing services by a home care nurse shall be limited according to this subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to home care nursing services apply to shared home care nursing services. Nothing in this subdivision shall be construed to reduce the total number of home care nursing hours authorized for an individual recipient.

(b) Shared home care nursing is the provision of nursing services by a home care nurse to two medical assistance eligible recipients at the same time and in the same setting. This subdivision does not apply when a home care nurse is caring for multiple recipients in more than one setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or foster care home of one of the individual recipients as defined in section 256B.0651;

(2) a child care program licensed under chapter 245A or operated by a local school district or private school;

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home residence or foster care home of one of the recipients when normal life activities take the recipients outside the home.

(d) The home care nursing agency must offer the recipient the option of shared or one-on-one home care nursing services. The recipient may withdraw from participating in a shared service arrangement at any time.

(e) The recipient or the recipient's legal representative, and the recipient's physician or advanced practice registered nurse, in conjunction with the home care nursing agency, shall determine:

(1) whether shared home care nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared home care nursing services authorized as part of the overall authorization of nursing services.

(f) The recipient or the recipient's legal representative, in conjunction with the home care nursing agency, shall approve the setting, grouping, and arrangement of shared home care nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(g) The following items must be considered by the recipient or the recipient's legal representative and the home care nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the home care nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared home care nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared home care nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(h) The documentation for shared home care nursing must be on a form approved by the commissioner for each individual recipient sharing home care nursing. The documentation must be part of the recipient's health service record and include:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing hours per week chosen by the recipient and permission for shared home care nursing services provided in and outside the recipient's home residence;

(2) revocation by the recipient or the recipient's legal representative for the shared home care nursing permission, or services provided to others in and outside the recipient's residence; and

(3) daily documentation of the shared home care nursing services provided by each identified home care nurse, including:

(i) the names of each recipient receiving shared home care nursing services;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared home care nursing care; and

(iii) notes by the home care nurse regarding changes in the recipient's condition, problems that may arise from the sharing of home care nursing services, and scheduling and care issues.

(i) The commissioner shall provide a rate methodology for shared home care nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times the regular home care nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared home care nursing care on the date for which the service is billed.

Sec. 132. Minnesota Statutes 2018, section 256B.0654, subdivision 4, is amended to read:

Subd. 4. **Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, family foster parents, spouses, and legal guardians who are providing home care nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient;

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient;

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate home care nursing services to meet the medical needs of the recipient.

(b) Home care nursing may be provided by a parent, spouse, family foster parent, or legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors, including Medicare. The home care nursing provided by a parent, spouse, family foster parent, or legal guardian must be included in the service agreement. Authorized nursing services for a single recipient or recipients with the same residence and provided by the parent, spouse, family foster parent, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents, spouse, family foster parent, or legal guardian shall not provide more than 40 hours of services in a seven-day period. For parents, family foster parents, and legal guardians, 40 hours is the total amount allowed regardless of the number of children or adults who receive services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent, family foster parent, or a spouse may not be paid to provide home care nursing care if:

(1) the parent or spouse fails to pass a criminal background check according to chapter 245C;

(2) it has been determined by the home care nursing agency, the case manager, or the physician or advanced practice registered nurse that the home care nursing provided by the parent, family foster parent, spouse, or legal guardian is unsafe; or

(3) the parent, family foster parent, spouse, or legal guardian does not follow physician or advanced practice registered nurse orders.

(d) For purposes of this section, "assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for home care nursing must be conducted by a registered nurse.

Sec. 133. Minnesota Statutes 2018, section 256B.0659, subdivision 2, is amended to read:

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with helping recipient with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, advanced practice registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Sec. 134. Minnesota Statutes 2018, section 256B.0659, subdivision 4, is amended to read:

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician or advanced practice registered nurse, specified in a personal care assistance care plan or community support plan developed under section 256B.0911, and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician or advanced practice registered nurse and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for recipients who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

Sec. 135. Minnesota Statutes 2018, section 256B.0659, subdivision 8, is amended to read:

Subd. 8. **Communication with recipient's physician or advanced practice registered nurse.** The personal care assistance program requires communication with the recipient's physician or advanced practice registered nurse about a recipient's assessed needs for personal care assistance services. The commissioner shall work with the state medical director to develop options for communication with the recipient's physician or advanced practice registered nurse.

Sec. 136. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components:

basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

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

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

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

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

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

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

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

Sec. 137. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256S.10. The plan shall include any services prescribed by the individual's attending physician or advanced practice registered nurse as necessary to allow the individual to

remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

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

Sec. 138. Minnesota Statutes 2018, section 256B.73, subdivision 5, is amended to read:

Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider shall receive a health services benefit package that includes health services which the enrollees might reasonably require to be maintained in good health, including emergency care, inpatient hospital and physician or advanced practice registered nurse care, outpatient health services, and preventive health services.

(b) Services related to chemical dependency, mental illness, vision care, dental care, and other benefits may be excluded or limited upon approval by the commissioners. The coalition may petition the commissioner of commerce or health, whichever is appropriate, for waivers that allow these benefits to be excluded or limited.

(c) The commissioners, the coalition, and demonstration providers shall work together to design a package of benefits or packages of benefits that can be provided to enrollees for an affordable monthly premium.

Sec. 139. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:

Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, a physician assistant, ~~a nurse practitioner~~ an advanced practice registered nurse, or a licensed chiropractor.

(b) For developmental disability and intelligence testing, a "qualified professional" means an individual qualified by training and experience to administer the tests necessary to make determinations, such as tests of intellectual functioning, assessments of adaptive behavior, adaptive skills, and developmental functioning. These professionals include licensed psychologists, certified school psychologists, or certified psychometrists working under the supervision of a licensed psychologist.

(c) For learning disabilities, a "qualified professional" means a licensed psychologist or school psychologist with experience determining learning disabilities.

(d) For mental health, a "qualified professional" means a licensed physician or a qualified mental health professional. A "qualified mental health professional" means:

(1) for children, in psychiatric nursing, a registered nurse or advanced practice registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) for adults, in psychiatric nursing, a registered nurse or advanced practice registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in clinical social work, a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(4) in psychology, an individual licensed by the Board of Psychology under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(5) in psychiatry, a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

(6) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; and

(7) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 140. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.

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

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

Sec. 141. Minnesota Statutes 2018, section 256R.54, subdivision 1, is amended to read:

Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The commissioner shall adopt rules under the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

(b) Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer.

(c) Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician or advanced practice registered nurse cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's or advanced practice registered nurse's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for services not medically necessary.

(d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) For purposes of this subdivision, "ancillary services" includes transportation defined as a covered service in section 256B.0625, subdivision 17.

Sec. 142. Minnesota Statutes 2018, section 256R.54, subdivision 2, is amended to read:

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician or advanced practice registered nurse and the treatment plan. If the recipient's medical record does not include these documents, the commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing facility for inclusion in the recipient's medical record. The commissioner shall make recommendations regarding the medical necessity of services provided.

Sec. 143. Minnesota Statutes 2018, section 257.63, subdivision 3, is amended to read:

Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered nurse concerning the medical circumstances of the pregnancy itself and the condition and characteristics of the child upon birth is not privileged.

Sec. 144. Minnesota Statutes 2018, section 257B.01, subdivision 3, is amended to read:

Subd. 3. **Attending physician or advanced practice registered nurse.** "Attending physician or advanced practice registered nurse" means a physician or advanced practice registered nurse who has primary responsibility for the treatment and care of the designator. If physicians or advanced practice registered nurses share responsibility, another physician or advanced practice registered nurse is acting on the attending physician's or advanced practice registered nurse's behalf, or no physician or advanced practice registered nurse has primary responsibility, any physician or advanced practice registered nurse who is familiar with the designator's medical condition may act as an attending physician or advanced practice registered nurse under this chapter.

Sec. 145. Minnesota Statutes 2018, section 257B.01, subdivision 9, is amended to read:

Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written finding made by an attending physician or advanced practice registered nurse which states

that the designator suffers from a physically incapacitating disease or injury. No identification of the illness in question is required.

Sec. 146. Minnesota Statutes 2018, section 257B.01, subdivision 10, is amended to read:

Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written finding made by an attending physician or advanced practice registered nurse which states the nature, extent, and probable duration of the designator's mental or organic incapacity.

Sec. 147. Minnesota Statutes 2018, section 257B.06, subdivision 7, is amended to read:

Subd. 7. **Restored capacity.** If a licensed physician or advanced practice registered nurse determines that the designator has regained capacity, the co-custodian's authority that commenced on the occurrence of a triggering event becomes inactive. Failure of a co-custodian to immediately return the child(ren) to the designator's care entitles the designator to an emergency hearing within five days of a request for a hearing.

Sec. 148. **REPEALER.**

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

Amend the title accordingly