

SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 13

(SENATE AUTHORS: BENSON, Draheim, Eichorn, Klein and Housley)

DATE	D-PG	OFFICIAL STATUS
01/10/2019	47	Introduction and first reading Referred to Health and Human Services Finance and Policy
02/07/2019	305	Author added Klein
02/21/2019	491	Author added Housley
03/13/2019	852a	Comm report: To pass as amended
	853	Second reading
04/04/2019	2165a	Special Order: Amended
	2165	Third reading Passed
05/17/2020	7413	Author stricken Anderson, P. Chief author stricken, shown as co-author Draheim Chief author added Benson
	7414	Returned from House with amendment
	7414	Senate concurred and repassed bill
	7414	Third reading Presentment date 05/18/2020

- 1.1 A bill for an act
- 1.2 relating to human services; modifying policy provisions governing health care;
- 1.3 specifying when a provider must furnish requested medical records; modifying
- 1.4 x-ray equipment provisions; requiring an annual unannounced inspection of medical
- 1.5 cannabis manufacturers; modifying eligibility for the reduced patient enrollment
- 1.6 fee for the medical cannabis program; permitting licensed physician assistants to
- 1.7 practice without a delegation agreement; modifying licensed traditional midwifery
- 1.8 scope of practice; modifying the request for proposal for a central drug repository;
- 1.9 authorizing pharmacists to prescribe self-administered hormonal contraceptives,
- 1.10 nicotine replacement medications, and opiate antagonists; allowing telemedicine
- 1.11 examinations to be used to prescribe medications for erectile dysfunction and for
- 1.12 the treatment of substance abuse disorders; changing the terminology and other
- 1.13 technical changes to the opiate epidemic response account and council; adding
- 1.14 advanced practice registered nurses to certain statutes; modifying definitions;
- 1.15 reclassifying certain controlled substances; modifying certain provisions related
- 1.16 to medical cannabis; amending Minnesota Statutes 2018, sections 62A.307,
- 1.17 subdivision 2; 62D.09, subdivision 1; 62E.06, subdivision 1; 62J.17, subdivision
- 1.18 4a; 62J.495, subdivision 1a; 62J.52, subdivision 2; 62J.823, subdivision 3; 62Q.43,
- 1.19 subdivisions 1, 2; 62Q.54; 62Q.57, subdivision 1; 62Q.73, subdivision 7; 62Q.733,
- 1.20 subdivision 3; 62Q.74, subdivision 1; 62S.08, subdivision 3; 62S.20, subdivision
- 1.21 5b; 62S.21, subdivision 2; 62S.268, subdivision 1; 62U.03; 62U.04, subdivision
- 1.22 11; 144.121, subdivisions 1, 2, 5, by adding subdivisions; 144.292, subdivisions
- 1.23 2, 5; 144.3345, subdivision 1; 144.3352; 144.34; 144.441, subdivisions 4, 5;
- 1.24 144.442, subdivision 1; 144.4803, subdivisions 1, 4, 10, by adding a subdivision;
- 1.25 144.4806; 144.4807, subdivisions 1, 2, 4; 144.50, subdivision 2; 144.55, subdivision
- 1.26 6; 144.6501, subdivision 7; 144.651, subdivisions 7, 8, 9, 10, 12, 14, 31, 33;
- 1.27 144.652, subdivision 2; 144.69; 144.7402, subdivision 2; 144.7406, subdivision
- 1.28 2; 144.7407, subdivision 2; 144.7414, subdivision 2; 144.7415, subdivision 2;
- 1.29 144.9502, subdivision 4; 144.966, subdivisions 3, 6; 144A.135; 144A.161,
- 1.30 subdivisions 5, 5a, 5e, 5g; 144A.75, subdivisions 3, 6; 144A.752, subdivision 1;
- 1.31 145.853, subdivision 5; 145.892, subdivision 3; 145.94, subdivision 2; 145B.13;
- 1.32 145C.02; 145C.06; 145C.07, subdivision 1; 145C.16; 147A.01, subdivisions 3,
- 1.33 21, 26, 27, by adding a subdivision; 147A.02; 147A.03, by adding a subdivision;
- 1.34 147A.05; 147A.09; 147A.13, subdivision 1; 147A.14, subdivision 4; 147A.16;
- 1.35 147A.23; 147D.03, subdivision 2; 148.6438, subdivision 1; 151.01, by adding a
- 1.36 subdivision; 151.071, subdivision 8; 151.19, subdivision 4; 151.21, subdivision
- 1.37 4a; 151.37, subdivision 2, by adding subdivisions; 152.02, subdivisions 2, 3, 4;
- 1.38 152.12, subdivision 1; 152.32, subdivision 3; 152.35; 245A.143, subdivision 8;

2.1 245A.1435; 245C.02, subdivision 18; 245C.04, subdivision 1; 245D.02, subdivision
 2.2 11; 245D.11, subdivision 2; 245D.22, subdivision 7; 245D.25, subdivision 2;
 2.3 245G.08, subdivisions 2, 5; 245G.21, subdivisions 2, 3; 246.711, subdivision 2;
 2.4 246.715, subdivision 2; 246.716, subdivision 2; 246.721; 246.722; 251.043,
 2.5 subdivision 1; 252A.02, subdivision 12; 252A.04, subdivision 2; 252A.20,
 2.6 subdivision 1; 253B.03, subdivisions 4, 6d; 253B.06, subdivision 2; 253B.23,
 2.7 subdivision 4; 254A.08, subdivision 2; 256.01, subdivision 29; 256.9685,
 2.8 subdivisions 1a, 1b, 1c; 256.975, subdivisions 7a, 11; 256B.04, subdivision 14a;
 2.9 256B.043, subdivision 2; 256B.055, subdivision 12; 256B.056, subdivisions 1a,
 2.10 4, 7, 10; 256B.0561, subdivision 2; 256B.057, subdivisions 1, 10; 256B.0575,
 2.11 subdivisions 1, 2; 256B.0622, subdivision 2b; 256B.0623, subdivision 2;
 2.12 256B.0625, subdivisions 1, 12, 13h, 26, 27, 28, 64; 256B.0654, subdivisions 1,
 2.13 2a, 3, 4; 256B.0659, subdivisions 2, 4, 8; 256B.0751; 256B.0753, subdivision 1;
 2.14 256B.69, by adding a subdivision; 256B.73, subdivision 5; 256B.75; 256J.08,
 2.15 subdivision 73a; 256L.03, subdivision 1; 256L.15, subdivision 1; 256R.54,
 2.16 subdivisions 1, 2; 257.63, subdivision 3; 257B.01, subdivisions 3, 9, 10; 257B.06,
 2.17 subdivision 7; 446A.081, subdivision 9; Minnesota Statutes 2019 Supplement,
 2.18 sections 16A.151, subdivision 2; 62J.23, subdivision 2; 62Q.184, subdivision 1;
 2.19 144.121, subdivisions 1a, 5a; 144.55, subdivision 2; 145C.05, subdivision 2;
 2.20 147A.06; 151.01, subdivisions 23, 27; 151.065, subdivisions 1, as amended, 3, as
 2.21 amended, 6, 7, as amended; 151.071, subdivision 2; 151.19, subdivision 3; 151.252,
 2.22 subdivision 1; 151.555, subdivision 3; 152.29, subdivision 1; 245G.08, subdivision
 2.23 3; 245H.11; 256.042, subdivisions 2, 4; 256.043; 256B.056, subdivision 7a;
 2.24 256B.0625, subdivisions 13, 17, 60a; 256B.0659, subdivision 11; 256B.0913,
 2.25 subdivision 8; 256R.44; Laws 2019, chapter 63, article 3, sections 1; 2; Laws 2019,
 2.26 First Special Session chapter 9, article 11, section 35; Laws 2020, chapter 73,
 2.27 section 4, subdivisions 3, 4; proposing coding for new law in Minnesota Statutes,
 2.28 chapters 62Q; 147A; repealing Minnesota Statutes 2018, sections 62U.15,
 2.29 subdivision 2; 144.121, subdivisions 3, 5b; 147A.01, subdivisions 4, 11, 16a, 17a,
 2.30 24, 25; 147A.04; 147A.10; 147A.11; 147A.18, subdivisions 1, 2, 3; 147A.20;
 2.31 256B.057, subdivision 8; 256B.0752; 256L.04, subdivision 13; Minnesota Rules,
 2.32 parts 7380.0280; 9505.0365, subpart 3.

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

2.34 **ARTICLE 1**

2.35 **DEPARTMENT OF HEALTH**

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

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

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

2.44 Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing
 2.45 radiation-producing equipment and other sources of ionizing radiation must pay an ~~annual~~

3.1 initial or annual renewal registration fee consisting of a base facility fee of \$100 and an
 3.2 additional fee for each ~~radiation source~~ x-ray tube, as follows:

- | | | |
|------|--------------------------------------|--------|
| 3.3 | (1) medical or veterinary equipment | \$ 100 |
| 3.4 | (2) dental x-ray equipment | \$ 40 |
| 3.5 | (3) x-ray equipment not used on | \$ 100 |
| 3.6 | humans or animals | |
| 3.7 | (4) devices with sources of ionizing | \$ 100 |
| 3.8 | radiation not used on humans or | |
| 3.9 | animals | |
| 3.10 | (5) security screening system | \$ 100 |

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

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

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

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

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

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

3.28 Subd. 2. **Inspections.** Periodic radiation safety inspections of the x-ray equipment and
 3.29 other sources of ionizing radiation shall be made by the ~~state~~ commissioner of health. The
 3.30 frequency of safety inspections shall be prescribed by the commissioner on the basis of the
 3.31 frequency of use of the x-ray equipment and other source of ionizing radiation~~s~~, provided
 3.32 that each source shall be inspected at least once every four years.

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

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

4.8 ~~(b) The commissioner shall establish criteria for the approval of examinations based on~~
4.9 ~~national standards, such as the examination in radiography from the American Registry of~~
4.10 ~~Radiologic Technologists, the examination for limited scope of practice in radiography from~~
4.11 ~~the American Registry of Radiologic Technologists for limited x-ray machine operators,~~
4.12 ~~and the American Registry of Chiropractic Radiography Technologists for limited~~
4.13 ~~radiography in spines and extremities; or equivalent examinations approved by other states.~~
4.14 ~~Equivalent examinations may be approved by the commissioner, if the examination is~~
4.15 ~~consistent with the standards for educational and psychological testing as recommended by~~
4.16 ~~the American Education Research Association, the American Psychological Association,~~
4.17 ~~the National Council on Measurement in Education, or the National Commission for~~
4.18 ~~Certifying Agencies. The organization proposing the use of an equivalent examination shall~~
4.19 ~~submit a fee to the commissioner of \$1,000 per examination to cover the cost of determining~~
4.20 ~~the extent to which the examination meets the examining standards. The collected fee shall~~
4.21 ~~be deposited in the state treasury and credited to the state government special revenue fund.~~

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

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

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

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

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

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

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

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

5.5 (8) an individual who has passed the examination for a dental hygienist under section
 5.6 150A.06 and only operates dental x-ray systems;

5.7 (9) an individual who has passed the examination for a dental therapist under section
 5.8 150A.06 and only operates dental x-ray systems;

5.9 (10) an individual who has passed the examination for a dental assistant under section
 5.10 150A.06, and only operates dental x-ray systems;

5.11 (11) an individual who has passed the examination under Minnesota Rules, part
 5.12 3100.8500, subpart 3, and only operates dental x-ray systems; and

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

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

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

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

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

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

5.28 (1) osteoporosis, bone physiology, bone health and patient education, patient preparation,
 5.29 fundamental principals, biological effects of radiation, units of measurements, radiation
 5.30 protection in bone densitometry, fundamentals of x-ray production, quality control, measuring
 5.31 bone mineral testing, determining quality in bone mineral testing, file and database
 5.32 management; and

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

6.4 ~~(d) (f) A limited scope x-ray operator, and a bone densitometry equipment operator,~~
 6.5 ~~who is are required to take an examination under this subdivision must submit to the~~
 6.6 ~~commissioner an a registration application for the examination, and a \$25 processing fee;~~
 6.7 ~~and the required examination fee set by the national organization offering the examination.~~
 6.8 ~~The processing fee and the examination fee shall be deposited in the state treasury and~~
 6.9 ~~credited to the state government special revenue fund. The commissioner shall submit the~~
 6.10 ~~fee to the national organization providing the examination.~~

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

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

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

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

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

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

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

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

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

7.7 ~~(ii) are under the personal supervision and in the physical presence of a qualified~~
 7.8 ~~practitioner for diagnosing or treating a disease or condition of the cardiovascular system~~
 7.9 ~~in fluoroscopically guided interventional procedures. Cardiovascular technologists may not~~
 7.10 ~~activate the fluoroscopic system or evaluate quality control tests.~~

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

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

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

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

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

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

7.30 Subd. 5d. Nuclear medicine technologist practice. (a) Nuclear medicine technologists
 7.31 who have passed the primary pathway credential in Nuclear Medicine Technology
 7.32 Certification Board (NMTCB) for nuclear medicine or the American Registry of Radiologic

8.1 Technologists (ARRT) for nuclear medicine technology or the American Society of Clinical
8.2 Pathologists (NM) (ASCP) may operate a fusion imaging device or a dual imaging device
8.3 that uses radioactive material as a point source in transmission scanning and attenuation
8.4 correction.

8.5 (b) A nuclear medicine technologist in paragraph (a) may only operate a stand-alone
8.6 computed tomography x-ray system if the technologist has passed the Nuclear Medicine
8.7 Technology Certification Board for computed tomography (CT) or is credentialed in
8.8 computed tomography (CT) from the American Registry of Radiologic Technologists
8.9 (ARRT).

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

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

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

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

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

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

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

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

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

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

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

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

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

9.16 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer ~~shall~~ may operate
9.17 eight distribution facilities, which may include the manufacturer's single location for
9.18 cultivation, harvesting, manufacturing, packaging, and processing but is not required to
9.19 include that location. The commissioner shall designate the geographical service areas to
9.20 be served by each manufacturer based on geographical need throughout the state to improve
9.21 patient access. A manufacturer shall not have more than two distribution facilities in each
9.22 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
9.23 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
9.24 and processing of medical cannabis shall be conducted. This location may be one of the
9.25 manufacturer's distribution facility sites. The additional distribution facilities may dispense
9.26 medical cannabis and medical cannabis products but may not contain any medical cannabis
9.27 in a form other than those forms allowed under section 152.22, subdivision 6, and the
9.28 manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or
9.29 processing at the other distribution facility sites. Any distribution facility operated by the
9.30 manufacturer is subject to all of the requirements applying to the manufacturer under sections
9.31 152.22 to 152.37, including, but not limited to, security and distribution requirements.

9.32 (b) A manufacturer may acquire hemp grown in this state from a hemp grower. A
9.33 manufacturer may manufacture or process hemp into an allowable form of medical cannabis

10.1 under section 152.22, subdivision 6. Hemp acquired by a manufacturer under this paragraph
10.2 is subject to the same quality control program, security and testing requirements, and other
10.3 requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota
10.4 Rules, chapter 4770.

10.5 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
10.6 commissioner, subject to any additional requirements set by the commissioner, for purposes
10.7 of testing medical cannabis manufactured or hemp acquired by the medical cannabis
10.8 manufacturer as to content, contamination, and consistency to verify the medical cannabis
10.9 meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall
10.10 be paid by the manufacturer.

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

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

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

10.17 (3) procedures for the delivery and transportation of hemp between hemp growers and
10.18 manufacturers.

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

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

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

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

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

10.30 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
10.31 of age or who has been convicted of a disqualifying felony offense. An employee of a
10.32 medical cannabis manufacturer must submit a completed criminal history records check

11.1 consent form, a full set of classifiable fingerprints, and the required fees for submission to
 11.2 the Bureau of Criminal Apprehension before an employee may begin working with the
 11.3 manufacturer. The bureau must conduct a Minnesota criminal history records check and
 11.4 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
 11.5 Investigation to obtain the applicant's national criminal history record information. The
 11.6 bureau shall return the results of the Minnesota and federal criminal history records checks
 11.7 to the commissioner.

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

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

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

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

11.21 (1) business operations;

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

11.24 (3) financial information and inventory documentation, including laboratory testing
 11.25 results; and

11.26 (4) physical and electronic security alarm systems.

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

11.28 **152.35 FEES; DEPOSIT OF REVENUE.**

11.29 (a) The commissioner shall collect an enrollment fee of \$200 from patients enrolled
 11.30 under this section. If the patient ~~attests to~~ provides evidence of receiving Social Security
 11.31 disability insurance (SSDI), Supplemental Security Insurance Income (SSI), veterans

12.1 disability, or railroad disability payments, or being enrolled in medical assistance or
12.2 MinnesotaCare, then the fee shall be \$50. For purposes of this section:

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

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

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

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

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

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

12.25 Sec. 14. Minnesota Statutes 2018, section 446A.081, subdivision 9, is amended to read:

12.26 Subd. 9. **Other uses of fund.** (a) The drinking water revolving loan fund may be used
12.27 as provided in the act, including the following uses:

12.28 (1) to buy or refinance the debt obligations, at or below market rates, of public water
12.29 systems for drinking water systems, where the debt was incurred after the date of enactment
12.30 of the act, for the purposes of construction of the necessary improvements to comply with
12.31 the national primary drinking water regulations under the federal Safe Drinking Water Act;

13.1 (2) to purchase or guarantee insurance for local obligations to improve credit market
13.2 access or reduce interest rates;

13.3 (3) to provide a source of revenue or security for the payment of principal and interest
13.4 on revenue or general obligation bonds issued by the authority if the bond proceeds are
13.5 deposited in the fund;

13.6 (4) to provide loans or loan guarantees for similar revolving funds established by a
13.7 governmental unit or state agency;

13.8 (5) to earn interest on fund accounts;

13.9 (6) to pay the reasonable costs incurred by the authority, the Department of Employment
13.10 and Economic Development, and the Department of Health for conducting activities as
13.11 authorized and required under the act up to the limits authorized under the act;

13.12 (7) to develop and administer programs for water system supervision, source water
13.13 protection, and related programs required under the act;

13.14 (8) ~~notwithstanding Minnesota Rules, part 7380.0280,~~ to provide principal forgiveness
13.15 or grants to the extent permitted under the federal Safe Drinking Water Act and other federal
13.16 law, based on the criteria and requirements established for drinking water projects under
13.17 the water infrastructure funding program under section 446A.072;

13.18 (9) to provide loans, principal forgiveness or grants to the extent permitted under the
13.19 federal Safe Drinking Water Act and other federal law to address green infrastructure, water
13.20 or energy efficiency improvements, or other environmentally innovative activities; ~~and~~

13.21 (10) to provide principal forgiveness, or grants for ~~50~~ 80 percent of ~~the project cost~~ costs
13.22 up to a maximum of ~~\$10,000~~ \$100,000 for projects needed to comply with national primary
13.23 drinking water standards for an existing nonmunicipal community ~~or noncommunity~~ public
13.24 water system; and

13.25 (11) to provide principal forgiveness or grants to the extent permitted under the federal
13.26 Safe Drinking Water Act and other federal laws for 50 percent of the project costs up to a
13.27 maximum of \$250,000 for projects to replace the privately owned portion of drinking water
13.28 lead service lines.

13.29 (b) Principal forgiveness or grants provided under paragraph (a), clause (9), may not
13.30 exceed 25 percent of the eligible project costs as determined by the Department of Health
13.31 for project components directly related to green infrastructure, water or energy efficiency
13.32 improvements, or other environmentally innovative activities, up to a maximum of
13.33 \$1,000,000.

14.1 Sec. 15. Laws 2019, First Special Session chapter 9, article 11, section 35, the effective
14.2 date, is amended to read:

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

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

14.5 Sec. 16. **AGE-RELATED MACULAR DEGENERATION; QUALIFYING MEDICAL**
14.6 **CONDITION.**

14.7 (a) In accordance with Minnesota Statutes, section 152.27, subdivision 2, paragraph (b),
14.8 the commissioner of health notified the legislature that the commissioner intends to add
14.9 age-related macular degeneration as a qualifying medical condition to the medical cannabis
14.10 program under Minnesota Statutes, section 152.22, subdivision 14.

14.11 (b) Minnesota Statutes, section 152. 27, subdivision 2, paragraph (b), specifies that the
14.12 proposed qualifying medical condition is added effective August 1 unless the legislature
14.13 by law provides otherwise.

14.14 (c) The legislature hereby states that age-related macular degeneration shall not be added
14.15 as a qualifying medical condition under Minnesota Statutes, section 152.22, subdivision
14.16 14.

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

14.18 Sec. 17. **REPEALER.**

14.19 (a) Minnesota Statutes 2018, section 144.121, subdivisions 3 and 5b, are repealed.

14.20 (b) Minnesota Rules, part 7380.0280, is repealed.

14.21 **ARTICLE 2**

14.22 **HEALTH-RELATED LICENSING BOARDS**

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

14.24 Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription
14.25 drugs must provide the same coverage for a prescription written by a health care provider
14.26 authorized to prescribe the particular drug covered by the health coverage described in
14.27 subdivision 1, regardless of the type of health care provider that wrote the prescription. This
14.28 section is intended to prohibit denial of coverage based on the prescription having been
14.29 written by an advanced practice nurse under section 148.235, a physician assistant under

15.1 section ~~147A.18~~ 147A.185, or any other nonphysician health care provider authorized to
 15.2 prescribe the particular drug.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.13 **147A.02 QUALIFICATIONS FOR LICENSURE.**

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

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

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

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

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

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

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

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

16.29 (7) has been approved by the board.

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

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

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

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

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

17.23 **147A.05 INACTIVE LICENSE.**

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

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

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

18.5 **147A.06 CANCELLATION OF LICENSE FOR NONRENEWAL.**

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

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

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

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

18.18 **147A.09 SCOPE OF PRACTICE, ~~DELEGATION.~~**

18.19 Subdivision 1. **Scope of practice.** Physician assistants shall practice medicine only ~~with~~
 18.20 ~~physician supervision. Physician assistants may perform those duties and responsibilities~~
 18.21 ~~as delegated in the physician-physician assistant delegation agreement and delegation forms~~
 18.22 ~~maintained at the address of record by the supervising physician and physician assistant,~~
 18.23 ~~including the prescribing, administering, and dispensing of drugs, controlled substances,~~
 18.24 ~~and medical devices, excluding anesthetics, other than local anesthetics, injected in~~
 18.25 ~~connection with an operating room procedure, inhaled anesthesia and spinal anesthesia~~
 18.26 under an established practice agreement.

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

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

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

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

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

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

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

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

19.12 (2) performing physical examinations;

19.13 (3) interpreting and evaluating patient data;

19.14 (4) ordering O_2 performing, or reviewing diagnostic procedures, including the use of
 19.15 radiographic imaging systems in compliance with Minnesota Rules 2007, chapter 4732, but
 19.16 excluding interpreting computed tomography scans, magnetic resonance imaging scans,
 19.17 positron emission tomography scans, nuclear scans, and mammography;

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

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

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

19.24 (8) creating and maintaining appropriate patient records;

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

19.26 (10) prescribing, administering, and dispensing drugs, controlled substances, and medical
 19.27 devices ~~if this function has been delegated by the supervising physician pursuant to and~~
 19.28 ~~subject to the limitations of section 147A.18 and chapter 151. For physician assistants who~~
 19.29 ~~have been delegated the authority to prescribe controlled substances, such delegation shall~~
 19.30 ~~be included in the physician-physician assistant delegation agreement, and all schedules of~~
 19.31 ~~controlled substances the physician assistant has the authority to prescribe shall be specified,~~

20.1 including administering local anesthetics, but excluding anesthetics injected in connection
20.2 with an operating room procedure, inhaled anesthesia, and spinal anesthesia;

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

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

20.9 ~~(13) (12) initiating evaluation and treatment procedures essential to providing an~~
20.10 ~~appropriate response to emergency situations;~~

20.11 ~~(14) (13) certifying a patient's eligibility for a disability parking certificate under section~~
20.12 ~~169.345, subdivision 2;~~

20.13 ~~(15) (14) assisting at surgery; and~~

20.14 ~~(16) (15) providing medical authorization for admission for emergency care and treatment~~
20.15 ~~of a patient under section 253B.05, subdivision 2.~~

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

20.19 Subd. 3. **Practice agreement review.** A physician assistant shall have a practice
20.20 agreement at the practice level that describes the practice of the physician assistant. The
20.21 practice agreement must be reviewed on an annual basis by a licensed physician within the
20.22 same clinic, hospital, health system, or other facility as the physician assistant and has
20.23 knowledge of the physician assistant's practice to ensure that the physician assistant's medical
20.24 practice is consistent with the practice agreement. A document stating that the review
20.25 occurred must be maintained at the practice level and made available to the board, upon
20.26 request.

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

21.1 Subd. 5. **Scope of practice limitations; psychiatric care for children with emotional**
 21.2 **disturbance or adults with serious mental illness.** Notwithstanding subdivision 1, a
 21.3 physician assistant may only provide ongoing psychiatric treatment for children with
 21.4 emotional disturbance, as defined in section 245.4871, subdivision 15, or adults with serious
 21.5 mental illness in collaboration with a physician licensed under chapter 147. For purposes
 21.6 of providing ongoing psychiatric treatment for children with emotional disturbance or adults
 21.7 with serious mental illness, the practice agreement between the physician assistant and one
 21.8 or more physicians licensed under chapter 147 must define the collaboration between the
 21.9 physician assistant and the collaborating physician, including appropriate consultation or
 21.10 referral to psychiatry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22.21 ~~(9)~~ (8) engaging in the practice of medicine beyond that what is allowed by the
22.22 ~~physician-physician assistant delegation agreement~~ under this chapter, or aiding or abetting
22.23 an unlicensed person in the practice of medicine;

22.24 ~~(10)~~ (9) adjudication as mentally incompetent, mentally ill or developmentally disabled,
22.25 or as a chemically dependent person, a person dangerous to the public, a sexually dangerous
22.26 person, or a person who has a sexual psychopathic personality by a court of competent
22.27 jurisdiction, within or without this state. Such adjudication shall automatically suspend a
22.28 license for its duration unless the board orders otherwise;

22.29 ~~(11)~~ (10) engaging in unprofessional conduct. Unprofessional conduct includes any
22.30 departure from or the failure to conform to the minimal standards of acceptable and prevailing
22.31 practice in which proceeding actual injury to a patient need not be established;

22.32 ~~(12)~~ (11) inability to practice with reasonable skill and safety to patients by reason of
22.33 illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material, or as

- 23.1 a result of any mental or physical condition, including deterioration through the aging
23.2 process or loss of motor skills;
- 23.3 ~~(13)~~ (12) revealing a privileged communication from or relating to a patient except when
23.4 otherwise required or permitted by law;
- 23.5 ~~(14)~~ (13) any identification of a physician assistant by the title "Physician," "~~Doctor,~~"
23.6 ~~or "Dr."~~ in a patient care setting or in a communication directed to the general public;
- 23.7 ~~(15)~~ (14) improper management of medical records, including failure to maintain adequate
23.8 medical records, to comply with a patient's request made pursuant to sections 144.291 to
23.9 144.298, or to furnish a medical record or report required by law;
- 23.10 ~~(16)~~ (15) engaging in abusive or fraudulent billing practices, including violations of the
23.11 federal Medicare and Medicaid laws or state medical assistance laws;
- 23.12 ~~(17)~~ (16) becoming addicted or habituated to a drug or intoxicant;
- 23.13 ~~(18)~~ (17) prescribing a drug or device for other than medically accepted therapeutic,
23.14 experimental, or investigative purposes authorized by a state or federal agency or referring
23.15 a patient to any health care provider as defined in sections 144.291 to 144.298 for services
23.16 or tests not medically indicated at the time of referral;
- 23.17 ~~(19)~~ (18) engaging in conduct with a patient which is sexual or may reasonably be
23.18 interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually
23.19 demeaning to a patient;
- 23.20 ~~(20)~~ (19) failure to make reports as required by section 147A.14 or to cooperate with an
23.21 investigation of the board as required by section 147A.15, subdivision 3;
- 23.22 ~~(21)~~ (20) knowingly providing false or misleading information that is directly related
23.23 to the care of that patient unless done for an accepted therapeutic purpose such as the
23.24 administration of a placebo;
- 23.25 ~~(22)~~ (21) aiding suicide or aiding attempted suicide in violation of section 609.215 as
23.26 established by any of the following:
- 23.27 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
23.28 of section 609.215, subdivision 1 or 2;
- 23.29 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
23.30 issued under section 609.215, subdivision 4;
- 23.31 (iii) a copy of the record of a judgment assessing damages under section 609.215,
23.32 subdivision 5; or

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

24.4 ~~(23) (22) failure to maintain annually reviewed and updated physician-physician assistant~~
 24.5 ~~delegation agreements for each physician-physician assistant practice relationship, or failure~~
 24.6 ~~to provide copies of such documents upon request by the board~~ failure to maintain the proof
 24.7 of review document as required under section 147A.09, subdivision 3, or to provide a copy
 24.8 of the document upon request of the board.

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

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

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

24.21 **147A.16 FORMS OF DISCIPLINARY ACTION.**

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

24.24 (1) revoke the license;

24.25 (2) suspend the license;

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

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

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

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

25.5 ~~(6)~~ (5) censure or reprimand the licensed physician assistant.

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

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

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

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

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

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

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

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

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

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

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

25.29 (1) the date of issue;

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

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

26.2 (4) directions for use; and

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

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

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

26.8 **147A.23 RESPONDING TO DISASTER SITUATIONS.**

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

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

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

26.25 Sec. 18. Minnesota Statutes 2018, section 147D.03, subdivision 2, is amended to read:

26.26 Subd. 2. **Scope of practice.** The practice of traditional midwifery includes; but is not
 26.27 limited to:

26.28 (1) initial and ongoing assessment for suitability of traditional midwifery care;

26.29 (2) providing prenatal education and coordinating with a licensed health care provider
 26.30 as necessary to provide comprehensive prenatal care, including the routine monitoring of
 26.31 vital signs, indicators of fetal developments, and ordering standard prenatal laboratory tests

27.1 and imaging, as needed, with attention to the physical, nutritional, and emotional needs of
 27.2 the woman and her family;

27.3 (3) attending and supporting the natural process of labor and birth;

27.4 (4) postpartum care of the mother and an initial assessment of the newborn; ~~and~~

27.5 (5) providing information and referrals to community resources on childbirth preparation,
 27.6 breastfeeding, exercise, nutrition, parenting, and care of the newborn-; and

27.7 (6) ordering ultrasounds, providing point-of-care testing, and ordering laboratory tests
 27.8 that conform to the standard prenatal protocol of the licensed traditional midwife's standard
 27.9 of care.

27.10 Sec. 19. Minnesota Statutes 2019 Supplement, section 151.01, subdivision 23, is amended
 27.11 to read:

27.12 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
 27.13 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
 27.14 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, ~~or~~ licensed
 27.15 advanced practice registered nurse. ~~For purposes of sections 151.15, subdivision 4; 151.211,~~
 27.16 ~~subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (c), and (f);~~
 27.17 ~~and 151.461, "practitioner" also means a, or licensed physician assistant authorized to~~
 27.18 ~~prescribe, dispense, and administer under chapter 147A.~~ For purposes of sections 151.15,
 27.19 subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2,
 27.20 paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense
 27.21 and administer under chapter 150A. For purposes of sections 151.252, subdivision 3, and
 27.22 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered
 27.23 hormonal contraceptives, nicotine replacement medications, or opiate antagonists under
 27.24 section 151.37, subdivision 14, 15, or 16.

27.25 Sec. 20. Minnesota Statutes 2019 Supplement, section 151.01, subdivision 27, is amended
 27.26 to read:

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

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

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

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

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

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

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

28.15 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
28.16 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
28.17 modification, administration, and discontinuation of drug therapy is according to the protocol
28.18 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
28.19 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
28.20 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
28.21 or medication administration made pursuant to a protocol or collaborative practice agreement
28.22 must be documented by the pharmacist in the patient's medical record or reported by the
28.23 pharmacist to a practitioner responsible for the patient's care;

28.24 (6) participation in administration of influenza vaccines and vaccines approved by the
28.25 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all
28.26 eligible individuals six years of age and older and all other vaccines to patients 13 years of
28.27 age and older by written protocol with a physician licensed under chapter 147, a physician
28.28 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered
28.29 nurse authorized to prescribe drugs under section 148.235, provided that:

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

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

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

28.33 (C) contraindications and precautions to the vaccine;

- 29.1 (D) the procedure for handling an adverse reaction;
- 29.2 (E) the name, signature, and address of the physician, physician assistant, or advanced
29.3 practice registered nurse;
- 29.4 (F) a telephone number at which the physician, physician assistant, or advanced practice
29.5 registered nurse can be contacted; and
- 29.6 (G) the date and time period for which the protocol is valid;
- 29.7 (ii) the pharmacist has successfully completed a program approved by the Accreditation
29.8 Council for Pharmacy Education specifically for the administration of immunizations or a
29.9 program approved by the board;
- 29.10 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
29.11 assess the immunization status of individuals prior to the administration of vaccines, except
29.12 when administering influenza vaccines to individuals age nine and older;
- 29.13 (iv) the pharmacist reports the administration of the immunization to the Minnesota
29.14 Immunization Information Connection; and
- 29.15 (v) the pharmacist complies with guidelines for vaccines and immunizations established
29.16 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
29.17 does not need to comply with those portions of the guidelines that establish immunization
29.18 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
29.19 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
29.20 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
29.21 drugs under section 148.235, provided that the order is consistent with the United States
29.22 Food and Drug Administration approved labeling of the vaccine;
- 29.23 (7) participation in the initiation, management, modification, and discontinuation of
29.24 drug therapy according to a written protocol or collaborative practice agreement between:
29.25 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
29.26 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
29.27 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
29.28 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
29.29 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement
29.30 must be documented by the pharmacist in the patient's medical record or reported by the
29.31 pharmacist to a practitioner responsible for the patient's care;
- 29.32 (8) participation in the storage of drugs and the maintenance of records;

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

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

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

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

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

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

30.14 Sec. 21. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to
 30.15 read:

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

30.20 Sec. 22. Minnesota Statutes 2018, section 151.37, subdivision 2, is amended to read:

30.21 **Subd. 2. Prescribing and filing.** (a) A licensed practitioner in the course of professional
 30.22 practice only, may prescribe, administer, and dispense a legend drug, and may cause the
 30.23 same to be administered by a nurse, a physician assistant, or medical student or resident
 30.24 under the practitioner's direction and supervision, and may cause a person who is an
 30.25 appropriately certified, registered, or licensed health care professional to prescribe, dispense,
 30.26 and administer the same within the expressed legal scope of the person's practice as defined
 30.27 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
 30.28 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
 30.29 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
 30.30 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
 30.31 27, to adhere to a particular practice guideline or protocol when treating patients whose
 30.32 condition falls within such guideline or protocol, and when such guideline or protocol

31.1 specifies the circumstances under which the legend drug is to be prescribed and administered.
31.2 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
31.3 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
31.4 This paragraph applies to a physician assistant only if the physician assistant meets the
31.5 requirements of section 147A.18.

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

31.16 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
31.17 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
31.18 practitioner's licensing board a statement indicating that the practitioner dispenses legend
31.19 drugs for profit, the general circumstances under which the practitioner dispenses for profit,
31.20 and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs
31.21 for profit after July 31, 1990, unless the statement has been filed with the appropriate
31.22 licensing board. For purposes of this paragraph, "profit" means (1) any amount received by
31.23 the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are
31.24 purchased in prepackaged form, or (2) any amount received by the practitioner in excess
31.25 of the acquisition cost of a legend drug plus the cost of making the drug available if the
31.26 legend drug requires compounding, packaging, or other treatment. The statement filed under
31.27 this paragraph is public data under section 13.03. This paragraph does not apply to a licensed
31.28 doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed
31.29 practitioner with the authority to prescribe, dispense, and administer a legend drug under
31.30 paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing
31.31 by a community health clinic when the profit from dispensing is used to meet operating
31.32 expenses.

31.33 (d) A prescription drug order for the following drugs is not valid, unless it can be
31.34 established that the prescription drug order was based on a documented patient evaluation,

32.1 including an examination, adequate to establish a diagnosis and identify underlying conditions
32.2 and contraindications to treatment:

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

32.4 (2) drugs defined by the Board of Pharmacy as controlled substances under section
32.5 152.02, subdivisions 7, 8, and 12;

32.6 (3) muscle relaxants;

32.7 (4) centrally acting analgesics with opioid activity;

32.8 (5) drugs containing butalbital; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33.21 Subd. 14. **Self-administered hormonal contraceptives.** (a) A pharmacist is authorized
33.22 to prescribe self-administered hormonal contraceptives if the intended use is contraception
33.23 in accordance with this subdivision. By January 1, 2021, the board shall develop a
33.24 standardized protocol for the pharmacist to follow in prescribing self-administrated hormonal
33.25 contraceptives. In developing the protocol, the board shall consult with the Minnesota Board
33.26 of Medical Practice; the Minnesota Board of Nursing; the commissioner of health; the
33.27 Minnesota section of the American Congress of Obstetricians and Gynecologists; professional
33.28 pharmacy associations; and professional associations of physicians, physician assistants,
33.29 and advanced practice registered nurses. The protocol must, at a minimum, include:

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

- 34.1 (2) requiring the pharmacist to review the screening tool with the patient;
- 34.2 (3) other assessments the pharmacist should make before prescribing self-administered
34.3 hormonal contraceptives;
- 34.4 (4) situations when the prescribing of self-administered hormonal contraceptives by a
34.5 pharmacist is contraindicated;
- 34.6 (5) situations when the pharmacist must refer a patient to the patient's primary care
34.7 provider or, if the patient does not have a primary care provider, to a nearby clinic or hospital;
34.8 and
- 34.9 (6) any additional information concerning the requirements and prohibitions in this
34.10 subdivision that the board considers necessary.
- 34.11 (b) Before a pharmacist is authorized to prescribe a self-administered hormonal
34.12 contraceptive to a patient under this subdivision, the pharmacist shall successfully complete
34.13 a training program on prescribing self-administered hormonal contraceptives that is offered
34.14 by a college of pharmacy or by a continuing education provider that is accredited by the
34.15 Accreditation Council for Pharmacy Education, or a program approved by the board. To
34.16 maintain authorization to prescribe, the pharmacist shall complete continuing education
34.17 requirements as specified by the board.
- 34.18 (c) Before prescribing a self-administered hormonal contraceptive, the pharmacist shall
34.19 follow the standardized protocol developed under paragraph (a), and if appropriate, may
34.20 prescribe a self-administered hormonal contraceptive to a patient, if the patient is:
- 34.21 (1) 18 years of age or older; or
- 34.22 (2) under the age of 18 if the patient has previously been prescribed a self-administered
34.23 hormonal contraceptive by a licensed physician, physician assistant, or advanced practice
34.24 registered nurse.
- 34.25 (d) The pharmacist shall provide counseling to the patient on the use of self-administered
34.26 hormonal contraceptives and provide the patient with a fact sheet that includes but is not
34.27 limited to the contraindications for use of the drug, the appropriate method for using the
34.28 drug, the need for medical follow-up, and any additional information listed in Minnesota
34.29 Rules, part 6800.0910, subpart 2, that is required to be given to a patient during the counseling
34.30 process. The pharmacist shall also provide the patient with a written record of the
34.31 self-administered hormonal contraceptive prescribed by the pharmacist.
- 34.32 (e) If a pharmacist prescribes and dispenses a self-administered hormonal contraceptive
34.33 under this subdivision, the pharmacist shall not prescribe a refill to the patient unless the

35.1 patient has evidence of a clinical visit with a physician, physician assistant, or advanced
35.2 practice registered nurse within the preceding three years.

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

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

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

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

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

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

35.32 (d) The pharmacist shall provide counseling to the patient on the use of the nicotine
35.33 replacement medication and provide the patient with a fact sheet that includes but is not

36.1 limited to the indications and contraindications for use of a nicotine replacement medication,
36.2 the appropriate method for using the medication or product, the need for medical follow-up,
36.3 and any additional information listed in Minnesota Rules, part 6800.0910, subpart 2, that
36.4 is required to be given to a patient during the counseling process. The pharmacist shall also
36.5 provide the patient with a written record of the medication prescribed by the pharmacist.

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

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

36.14 Sec. 25. Minnesota Statutes 2018, section 151.37, is amended by adding a subdivision to
36.15 read:

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

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

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

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

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

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

37.16 Sec. 26. Minnesota Statutes 2019 Supplement, section 151.555, subdivision 3, is amended
37.17 to read:

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

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

37.27 (c) The central repository shall be subject to inspection by the board pursuant to section
37.28 151.06, subdivision 1.

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

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

38.1 Sec. 27. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

38.2 Subdivision 1. **Prescribing, dispensing, administering controlled substances in**
38.3 **Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine,
38.4 duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine,
38.5 a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed
38.6 physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and
38.7 in the course of professional practice only, may prescribe, administer, and dispense a
38.8 controlled substance included in Schedules II through V of section 152.02, may cause the
38.9 same to be administered by a nurse, an intern or an assistant under the direction and
38.10 supervision of the doctor, and may cause a person who is an appropriately certified and
38.11 licensed health care professional to prescribe and administer the same within the expressed
38.12 legal scope of the person's practice as defined in Minnesota Statutes.

38.13 Sec. 28. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is
38.14 amended to read:

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

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

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

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

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

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

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

39.19 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
39.20 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
39.21 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
39.22 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
39.23 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
39.24 individuals, medical assistance may cover drugs from the drug classes listed in United States
39.25 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
39.26 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
39.27 not be covered.

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

39.32 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
39.33 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
39.34 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a

40.1 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
40.2 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
40.3 pharmacist in accordance with section 151.37, subdivision 16.

40.4 Sec. 29. Minnesota Statutes 2018, section 256B.0625, subdivision 13h, is amended to
40.5 read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42.1 Sec. 30. **ISSUANCE OF PRESCRIPTIONS TO TREAT SUBSTANCE USE**
42.2 **DISORDERS.**

42.3 **Subdivision 1. Applicability during a peacetime emergency.** This section applies
42.4 during a peacetime emergency declared by the governor under Minnesota Statutes, section
42.5 12.31, subdivision 2, for an outbreak of COVID-19.

42.6 **Subd. 2. Use of telemedicine allowed.** For purposes of Minnesota Statutes, section
42.7 151.37, subdivision 2, paragraph (d), the requirement for an examination shall be met if the
42.8 prescribing practitioner has performed a telemedicine examination of the patient before
42.9 issuing a prescription drug order for the treatment of a substance use disorder.

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

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

42.13 Sec. 31. **LICENSE RENEWAL FOR PODIATRISTS; CONTINUING EDUCATION.**

42.14 **(a) Notwithstanding Minnesota Statutes, section 153.16, subdivision 5, for purposes of**
42.15 **obtaining the required hours of continuing education for licensure renewal, any continuing**
42.16 **education hours obtained by a licensed podiatrist through participation in an internet live**
42.17 **online continuing educational activity as defined by the Council on Podiatric Medical**
42.18 **Education from March 13, 2020, to the expiration date of this section, shall be classified**
42.19 **by the board of podiatric medicine in the same manner as if the credits were obtained through**
42.20 **in-person participation.**

42.21 **(b) This section expires December 31, 2020, or the day after the peacetime emergency**
42.22 **declared by the governor under Minnesota Statutes, section 12.31, subdivision 2, for an**
42.23 **outbreak of COVID-19 is terminated or rescinded by proper authority, whichever is later.**

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

42.25 Sec. 32. **OBSERVATION OF PHYSICAL THERAPIST ASSISTANTS.**

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

42.29 **Subd. 2. On-site requirements.** For purposes of Minnesota Statutes, section 148.706,
42.30 subdivision 3, the on-site observation requirement of treatment components delegated to a

43.1 physical therapist assistant by a physical therapist may be met through observation via
43.2 telemedicine.

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

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

43.6 Sec. 33. **THERAPEUTIC INTERCHANGE.**

43.7 Subdivision 1. **Applicability during a peacetime emergency.** This section applies
43.8 during a peacetime emergency declared by the governor under Minnesota Statutes, section
43.9 12.31, subdivision 2, for an outbreak of COVID-19.

43.10 Subd. 2. **Therapeutic interchange.** Notwithstanding Minnesota Statutes, section 151.21,
43.11 subdivision 7a, paragraph (a), a pharmacist may dispense a therapeutically equivalent and
43.12 interchangeable prescribed drug or biological product, without having a protocol in place,
43.13 provided:

43.14 (1) the drug prescribed is in short supply and the pharmacist is unable to obtain it from
43.15 the manufacturer, drug wholesalers, or other local pharmacies;

43.16 (2) the pharmacist is unable to contact the prescriber within a reasonable period of time
43.17 to get authorization to dispense a drug that is available;

43.18 (3) the pharmacist determines a therapeutically equivalent drug to the one prescribed is
43.19 available and is in the same American Hospital Formulary Service pharmacologic-therapeutic
43.20 classification;

43.21 (4) the pharmacist informs the patient as required in Minnesota Statutes, section 151.21,
43.22 subdivision 7a, paragraph (b), and provides counseling to the patient, as required by the
43.23 Board of Pharmacy rules, about the substituted drug;

43.24 (5) the pharmacist informs the prescriber as soon as possible that the therapeutic
43.25 interchange has been made; and

43.26 (6) the therapeutic interchange pursuant to this section is allowed only until the expiration
43.27 date under subdivision 3.

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

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

44.1 Sec. 34. **REPEALER.**

44.2 Minnesota Statutes 2018, sections 147A.01, subdivisions 4, 11, 16a, 17a, 24, and 25;
44.3 147A.04; 147A.10; 147A.11; 147A.18, subdivisions 1, 2, and 3; and 147A.20, are repealed.

44.4 **ARTICLE 3**44.5 **HEALTH CARE**

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

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

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

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

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

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

44.27 (f) Any money received by the state resulting from a settlement agreement or an assurance
44.28 of discontinuance entered into by the attorney general of the state, or a court order in litigation
44.29 brought by the attorney general of the state, on behalf of the state or a state agency, against
44.30 one or more opioid manufacturers or opioid wholesale drug distributors related to alleged
44.31 violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this
44.32 state or other alleged illegal actions that contributed to the excessive use of opioids, must

45.1 be deposited in a separate account in the state treasury and the commissioner shall notify
 45.2 the chairs and ranking minority members of the Finance Committee in the senate and the
 45.3 Ways and Means Committee in the house of representatives that an account has been created.
 45.4 This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney
 45.5 General's Office, to contract attorneys hired by the state or Attorney General's Office, or to
 45.6 other state agency attorneys. If the licensing fees under section 151.065, subdivision 1,
 45.7 clause (16), and subdivision 3, clause (14), are reduced and the registration fee under section
 45.8 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, then
 45.9 the commissioner shall transfer from the separate account created in this paragraph to the
 45.10 opiate epidemic response ~~account~~ fund under section 256.043 an amount that ensures that
 45.11 \$20,940,000 each fiscal year is available for distribution in accordance with section 256.043,
 45.12 subdivisions 2 and 3.

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

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

45.15 **62U.03 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.**

45.16 (a) By January 1, 2010, health plan companies shall include health care homes in their
 45.17 provider networks and by July 1, 2010, shall pay a care coordination fee for their members
 45.18 who choose to enroll in health care homes certified by the ~~commissioners of health and~~
 45.19 ~~human services~~ commissioner under section 256B.0751. Health plan companies shall develop
 45.20 payment conditions and terms for the care coordination fee for health care homes participating
 45.21 in their network in a manner that is consistent with the system developed under section
 45.22 256B.0753. Nothing in this section shall restrict the ability of health plan companies to
 45.23 selectively contract with health care providers, including health care homes. Health plan
 45.24 companies may reduce or reallocate payments to other providers to ensure that
 45.25 implementation of care coordination payments is cost neutral.

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

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

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

46.2 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
46.3 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
46.4 designee shall only use the data submitted under subdivisions 4 and 5 for the following
46.5 purposes:

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

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

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

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

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

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

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

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

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

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

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

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

47.1 (d) The commissioner or the commissioner's designee may use the data submitted under
47.2 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
47.3 2023.

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

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

47.8 Sec. 4. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 1, as amended
47.9 by Laws 2020, chapter 71, article 2, section 5, is amended to read:

47.10 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
47.11 follows:

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

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

47.14 (3) pharmacy intern, \$50;

47.15 (4) pharmacy technician, \$50;

47.16 (5) pharmacy, \$260;

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

47.18 (7) drug wholesaler, legend and nonlegend drugs, \$5,260;

47.19 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;

47.20 (9) drug wholesaler, medical gases, \$5,260 for the first facility and \$260 for each
47.21 additional facility;

47.22 (10) third-party logistics provider, \$260;

47.23 (11) drug manufacturer, nonopiate legend drugs only, \$5,260;

47.24 (12) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;

47.25 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$5,260;

47.26 (14) drug manufacturer, medical gases, \$5,260 for the first facility and \$260 for each
47.27 additional facility;

47.28 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;

48.1 (16) drug manufacturer of opiate-containing controlled substances listed in section
48.2 152.02, subdivisions 3 to 5, ~~\$55,000~~ \$55,260;

48.3 (17) medical gas ~~distributor~~ dispenser, \$260;

48.4 (18) controlled substance researcher, \$75; and

48.5 (19) pharmacy professional corporation, \$150.

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

48.7 Sec. 5. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 3, as amended
48.8 by Laws 2020, chapter 71, article 2, section 6, is amended to read:

48.9 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
48.10 follows:

48.11 (1) pharmacist, \$175;

48.12 (2) pharmacy technician, \$50;

48.13 (3) pharmacy, \$260;

48.14 (4) drug wholesaler, legend drugs only, \$5,260;

48.15 (5) drug wholesaler, legend and nonlegend drugs, \$5,260;

48.16 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;

48.17 (7) drug wholesaler, medical gases, \$5,260 for the first facility and \$260 for each
48.18 additional facility;

48.19 (8) third-party logistics provider, \$260;

48.20 (9) drug manufacturer, nonopiate legend drugs only, \$5,260;

48.21 (10) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;

48.22 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$5,260;

48.23 (12) drug manufacturer, medical gases, \$5,260 for the first facility and \$260 for each
48.24 additional facility;

48.25 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;

48.26 (14) drug manufacturer of opiate-containing controlled substances listed in section
48.27 152.02, subdivisions 3 to 5, ~~\$55,000~~ \$55,260;

48.28 (15) medical gas ~~distributor~~ dispenser, \$260;

49.1 (16) controlled substance researcher, \$75; and

49.2 (17) pharmacy professional corporation, \$100.

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

49.4 Sec. 6. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 6, is amended
49.5 to read:

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

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

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

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

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

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

49.23 Sec. 7. Minnesota Statutes 2019 Supplement, section 151.065, subdivision 7, as amended
49.24 by Laws 2020, chapter 71, article 2, section 7, is amended to read:

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

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

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

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

50.5 Sec. 8. Minnesota Statutes 2019 Supplement, section 151.071, subdivision 2, is amended
 50.6 to read:

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

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

50.12 (2) obtaining a license by fraud or by misleading the board in any way during the
 50.13 application process or obtaining a license by cheating, or attempting to subvert the licensing
 50.14 examination process. Conduct that subverts or attempts to subvert the licensing examination
 50.15 process includes, but is not limited to: (i) conduct that violates the security of the examination
 50.16 materials, such as removing examination materials from the examination room or having
 50.17 unauthorized possession of any portion of a future, current, or previously administered
 50.18 licensing examination; (ii) conduct that violates the standard of test administration, such as
 50.19 communicating with another examinee during administration of the examination, copying
 50.20 another examinee's answers, permitting another examinee to copy one's answers, or
 50.21 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
 50.22 impersonator to take the examination on one's own behalf;

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

50.32 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
 50.33 or applicant is convicted of a felony reasonably related to the operation of the facility. The

51.1 board may delay the issuance of a new license or registration if the owner or applicant has
51.2 been charged with a felony until the matter has been adjudicated;

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

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

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

51.16 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
51.17 license or registration issued by another of this state's health licensing agencies, failure to
51.18 report to the board that charges regarding the person's license or registration have been
51.19 brought by another of this state's health licensing agencies, or having been refused a license
51.20 or registration by another of this state's health licensing agencies. The board may delay the
51.21 issuance of a new license or registration if a disciplinary action is pending before another
51.22 of this state's health licensing agencies until the action has been dismissed or otherwise
51.23 resolved;

51.24 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
51.25 any order of the board, of any of the provisions of this chapter or any rules of the board or
51.26 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
51.27 pharmacy;

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

51.31 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
51.32 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
51.33 a patient; or pharmacy practice that is professionally incompetent, in that it may create

52.1 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
52.2 actual injury need not be established;

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

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

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

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

52.20 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
52.21 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
52.22 of material or as a result of any mental or physical condition, including deterioration through
52.23 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
52.24 pharmacist interns, or controlled substance researchers, the inability to carry out duties
52.25 allowed under this chapter or the rules of the board with reasonable skill and safety to
52.26 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
52.27 of material or as a result of any mental or physical condition, including deterioration through
52.28 the aging process or loss of motor skills;

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

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

53.4 (17) fee splitting, including without limitation:

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

53.7 (ii) referring a patient to any health care provider as defined in sections 144.291 to
53.8 144.298 in which the licensee or registrant has a financial or economic interest as defined
53.9 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
53.10 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
53.11 and

53.12 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
53.13 does not have a significant ownership interest, fills a prescription drug order and the
53.14 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
53.15 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
53.16 benefit manager, or other person paying for the prescription or, in the case of veterinary
53.17 patients, the price for the filled prescription that is charged to the client or other person
53.18 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
53.19 an arrangement provided that the client or other person paying for the prescription is notified,
53.20 in writing and with each prescription dispensed, about the arrangement, unless such
53.21 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
53.22 production systems, in which case client notification would not be required;

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

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

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

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

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

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

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

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

54.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
 54.10 The board ~~shall~~ must investigate any complaint of a violation of section 609.215, subdivision
 54.11 1 or 2;

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

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

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

54.21 Sec. 9. Minnesota Statutes 2018, section 151.071, subdivision 8, is amended to read:

54.22 Subd. 8. **Temporary suspension of license for pharmacies, drug wholesalers, drug**
 54.23 **manufacturers, medical gas manufacturers, and medical gas ~~distributors~~ dispensers.** In
 54.24 addition to any other remedy provided by law, the board may, without a hearing, temporarily
 54.25 suspend the license or registration of a pharmacy, drug wholesaler, drug manufacturer,
 54.26 medical gas manufacturer, or medical gas ~~distributor~~ dispenser if the board finds that the
 54.27 licensee or registrant has violated a statute or rule that the board is empowered to enforce
 54.28 and continued operation of the licensed facility would create a serious risk of harm to the
 54.29 public. The suspension ~~shall~~ must take effect upon written notice to the licensee or registrant,
 54.30 specifying the statute or rule violated. The suspension ~~shall~~ must remain in effect until the
 54.31 board issues a final order in the matter after a hearing. At the time it issues the suspension
 54.32 notice, the board ~~shall~~ must schedule a disciplinary hearing to be held pursuant to the
 54.33 Administrative Procedure Act. The licensee or registrant ~~shall~~ must be provided with at

55.1 least 20 days' notice of any hearing held pursuant to this subdivision. The hearing ~~shall~~ must
 55.2 be scheduled to begin no later than 30 days after the issuance of the suspension order.

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

55.4 Sec. 10. Minnesota Statutes 2019 Supplement, section 151.19, subdivision 3, is amended
 55.5 to read:

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

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

55.15 (c) ~~No~~ A registration ~~shall~~ must not be issued or renewed for a medical gas ~~distributor~~
 55.16 dispenser located within the state unless the applicant agrees to operate in a manner prescribed
 55.17 by federal and state law and according to the rules adopted by the board. ~~No~~ A license ~~shall~~
 55.18 must not be issued for a medical gas ~~distributor~~ dispenser located outside of the state unless
 55.19 the applicant agrees to operate in a manner prescribed by federal law and, when ~~distributing~~
 55.20 dispensing medical gases for residents of this state, the laws of this state and Minnesota
 55.21 Rules.

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

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

55.31 (f) Prior to the issuance of an initial or renewed registration for a medical gas ~~distributor~~
 55.32 dispenser, the board may require the medical gas ~~distributor~~ dispenser to pass an inspection
 55.33 conducted by an authorized representative of the board. In the case of a medical gas

56.1 ~~distributor~~ dispenser located outside of the state, the board may require the applicant to pay
 56.2 the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant
 56.3 furnishes the board with a report, issued by the appropriate regulatory agency of the state
 56.4 in which the facility is located, of an inspection that has occurred within the 24 months
 56.5 immediately preceding receipt of the license application by the board. The board may deny
 56.6 licensure unless the applicant submits documentation satisfactory to the board that any
 56.7 deficiencies noted in an inspection report have been corrected.

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

56.9 Sec. 11. Minnesota Statutes 2019 Supplement, section 151.252, subdivision 1, is amended
 56.10 to read:

56.11 Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without
 56.12 first obtaining a license from the board and paying any applicable fee specified in section
 56.13 151.065.

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

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

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

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

56.31 (f) No license shall be issued or renewed for a drug manufacturer that is required to be
 56.32 licensed or registered by the state in which it is physically located unless the applicant
 56.33 supplies the board with proof of licensure or registration. The board may establish, by rule,

57.1 standards for the licensure of a drug manufacturer that is not required to be licensed or
57.2 registered by the state in which it is physically located.

57.3 (g) The board shall require a separate license for each facility located within the state at
57.4 which drug manufacturing occurs and for each facility located outside of the state at which
57.5 drugs that are shipped into the state are manufactured, except a manufacturer of
57.6 opiate-containing controlled substances shall not be required to pay the fee under section
57.7 151.065, subdivision 1, clause (16), or subdivision 3, clause (14), for more than one facility.

57.8 (h) Prior to the issuance of an initial or renewed license for a drug manufacturing facility,
57.9 the board may require the facility to pass a current good manufacturing practices inspection
57.10 conducted by an authorized representative of the board. In the case of a drug manufacturing
57.11 facility located outside of the state, the board may require the applicant to pay the cost of
57.12 the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes
57.13 the board with a report, issued by the appropriate regulatory agency of the state in which
57.14 the facility is located or by the United States Food and Drug Administration, of an inspection
57.15 that has occurred within the 24 months immediately preceding receipt of the license
57.16 application by the board. The board may deny licensure unless the applicant submits
57.17 documentation satisfactory to the board that any deficiencies noted in an inspection report
57.18 have been corrected.

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

57.20 Sec. 12. Minnesota Statutes 2018, section 256.01, subdivision 29, is amended to read:

57.21 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
57.22 determinations of disability by the commissioner's state medical review team under sections
57.23 ~~256B.055, subdivision~~ subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9,
57.24 ~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted~~
57.25 ~~by county agencies with a referral~~ and seek ~~additional~~ information from providers, applicants,
57.26 and enrollees to support the determination of disability where necessary. Disability shall
57.27 be determined according to the rules of title XVI and title XIX of the Social Security Act
57.28 and pertinent rules and policies of the Social Security Administration.

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

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

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

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

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

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

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

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

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

58.21 Sec. 13. Minnesota Statutes 2019 Supplement, section 256.042, subdivision 2, is amended
 58.22 to read:

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

58.26 (1) two members of the house of representatives, appointed in the following sequence:
 58.27 the first from the majority party appointed by the speaker of the house and the second from
 58.28 the minority party appointed by the minority leader. Of these two members, one member
 58.29 must represent a district outside of the seven-county metropolitan area, and one member
 58.30 must represent a district that includes the seven-county metropolitan area. The appointment
 58.31 by the minority leader must ensure that this requirement for geographic diversity in
 58.32 appointments is met;

59.1 (2) two members of the senate, appointed in the following sequence: the first from the
59.2 majority party appointed by the senate majority leader and the second from the minority
59.3 party appointed by the senate minority leader. Of these two members, one member must
59.4 represent a district outside of the seven-county metropolitan area and one member must
59.5 represent a district that includes the seven-county metropolitan area. The appointment by
59.6 the minority leader must ensure that this requirement for geographic diversity in appointments
59.7 is met;

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

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

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

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

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

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

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

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

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

59.27 (12) two members representing Indian tribes, one representing the Ojibwe tribes and
59.28 one representing the Dakota tribes;

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

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

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

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

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

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

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

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

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

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

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

60.21 Sec. 14. Minnesota Statutes 2019 Supplement, section 256.042, subdivision 4, is amended
60.22 to read:

60.23 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the
60.24 grants proposed by the advisory council to be awarded for the upcoming fiscal year to the
60.25 chairs and ranking minority members of the legislative committees with jurisdiction over
60.26 health and human services policy and finance, by March 1 of each year, beginning March
60.27 1, 2020.

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

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

61.2 Sec. 15. Minnesota Statutes 2019 Supplement, section 256.043, is amended to read:

61.3 **256.043 OPIATE EPIDEMIC RESPONSE ACCOUNT FUND.**

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

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

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

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

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

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

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

61.27 ~~(b)~~ (d) After the ~~transfers in subdivision 2 and the appropriations in paragraph~~ paragraphs
61.28 (a) to (c) are made, 50 percent of the remaining amount is appropriated to the commissioner
61.29 of human services for distribution to county social service and tribal social service agencies
61.30 to provide child protection services to children and families who are affected by addiction.
61.31 The commissioner shall distribute this money proportionally to counties and tribal social
61.32 service agencies based on out-of-home placement episodes where parental drug abuse is

62.1 the primary reason for the out-of-home placement using data from the previous calendar
 62.2 year. County and tribal social service agencies receiving funds from the opiate epidemic
 62.3 response ~~account~~ fund must annually report to the commissioner on how the funds were
 62.4 used to provide child protection services, including measurable outcomes, as determined
 62.5 by the commissioner. County social service agencies and tribal social service agencies must
 62.6 not use funds received under this paragraph to supplant current state or local funding received
 62.7 for child protection services for children and families who are affected by addiction.

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

62.12 Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of \$250,000,000 either
 62.13 as a result of a settlement agreement or an assurance of discontinuance entered into by the
 62.14 attorney general of the state, or resulting from a court order in litigation brought by the
 62.15 attorney general of the state on behalf of the state or a state agency, against one or more
 62.16 opioid manufacturers or opioid wholesale drug distributors related to alleged violations of
 62.17 consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other
 62.18 alleged illegal actions that contributed to the excessive use of opioids, or from the fees
 62.19 collected under sections 151.065, subdivisions 1 and 3, and 151.066, that are deposited into
 62.20 the opiate epidemic response ~~account~~ fund established in this section ~~256.043~~, or from a
 62.21 combination of both, the fees specified in section 151.065, subdivisions 1, clause (16), and
 62.22 3, clause (14), shall be reduced to \$5,260, and the opiate registration fee in section 151.066,
 62.23 subdivision 3, shall be repealed.

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

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

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

62.31 Sec. 16. Minnesota Statutes 2018, section 256B.056, subdivision 1a, is amended to read:

62.32 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law
 62.33 or rule or federal law or regulation, the methodologies used in counting income and assets

63.1 to determine eligibility for medical assistance for persons whose eligibility category is based
 63.2 on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental
 63.3 Security Income program shall be used, except as provided under subdivision 3, paragraph
 63.4 (a), clause (6).

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

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

63.15 (i) children under age 19 and their parents and relative caretakers as defined in section
 63.16 256B.055, subdivision 3a;

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

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

63.19 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision
 63.20 § 1; and

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

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

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

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

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

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

64.1 Sec. 17. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

64.2 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
64.3 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
64.4 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
64.5 Supplemental Security Income may have an income up to the Supplemental Security Income
64.6 standard in effect on that date.

64.7 (b) ~~Effective January 1, 2014,~~ To be eligible for medical assistance, under section
64.8 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
64.9 percent of the federal poverty guidelines for the household size.

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

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

64.16 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
64.17 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
64.18 household size ~~or an equivalent standard when converted using modified adjusted gross
64.19 income methodology as required under the Affordable Care Act. Children who are enrolled
64.20 in medical assistance as of December 31, 2013, and are determined ineligible for medical
64.21 assistance because of the elimination of income disregards under modified adjusted gross
64.22 income methodology as defined in subdivision 1a remain eligible for medical assistance
64.23 under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law
64.24 111-3, until the date of their next regularly scheduled eligibility redetermination as required
64.25 in subdivision 7a.~~

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

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

65.1 Sec. 18. Minnesota Statutes 2018, section 256B.056, subdivision 7, is amended to read:

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

65.5 (b) For a person eligible for an insurance affordability program as defined in section
65.6 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
65.7 assistance, eligibility is available for the month the change was reported and for three months
65.8 prior to the month the change was reported, if the person was eligible in those prior months.

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

65.10 Sec. 19. Minnesota Statutes 2019 Supplement, section 256B.056, subdivision 7a, is
65.11 amended to read:

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

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

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

65.27 (d) Notwithstanding paragraph (a), ~~individuals~~ a person who is eligible under subdivision
65.28 ~~5 shall be required to renew eligibility~~ 5 shall be required to renew eligibility subject to a review of the person's income every six
65.29 months.

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

66.1 Sec. 20. Minnesota Statutes 2018, section 256B.056, subdivision 10, is amended to read:

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

66.6 (b) The commissioner shall determine the eligibility of private-sector health care coverage
66.7 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
66.8 256B.057, subdivision 1, paragraph ~~(b)~~ (c), and shall pay for private-sector coverage if this
66.9 is determined to be cost-effective.

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

66.12 (d) The commissioner shall utilize information obtained through the electronic service
66.13 established by the secretary of the United States Department of Health and Human Services
66.14 and other available electronic data sources in Code of Federal Regulations, title 42, sections
66.15 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
66.16 standards to define when information obtained electronically is reasonably compatible with
66.17 information provided by applicants and enrollees, including use of self-attestation, to
66.18 accomplish real-time eligibility determinations and maintain program integrity.

66.19 (e) Each person applying for or receiving medical assistance under section 256B.055,
66.20 subdivision 7, and any other person whose resources are required by law to be disclosed to
66.21 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
66.22 information from financial institutions to identify unreported accounts as required in section
66.23 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner
66.24 may determine that the applicant or recipient is ineligible for medical assistance. For purposes
66.25 of this paragraph, an authorization to identify unreported accounts meets the requirements
66.26 of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not
66.27 be furnished to the financial institution.

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

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

67.1 Sec. 21. Minnesota Statutes 2018, section 256B.0561, subdivision 2, is amended to read:

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

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

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

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

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

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

67.27 Sec. 22. Minnesota Statutes 2018, section 256B.057, subdivision 1, is amended to read:

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

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

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

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

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

68.11 Sec. 23. Minnesota Statutes 2018, section 256B.057, subdivision 10, is amended to read:

68.12 Subd. 10. **Certain persons needing treatment for breast or cervical cancer.** (a)

68.13 Medical assistance may be paid for a person who:

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

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

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

68.23 (4) is under age 65;

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

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

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

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

69.4 Sec. 24. Minnesota Statutes 2018, section 256B.0575, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

70.24 Sec. 25. Minnesota Statutes 2018, section 256B.0575, subdivision 2, is amended to read:

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

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

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

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

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

71.5 (5) for private room fees incurred by an assisted living client as defined in section
71.6 144G.01, subdivision 3.

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

71.8 Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

72.8 Sec. 28. Minnesota Statutes 2018, section 256B.0625, subdivision 64, is amended to read:

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

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

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

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

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

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

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

73.1 Sec. 29. Minnesota Statutes 2018, section 256B.0751, is amended to read:

73.2 **256B.0751 HEALTH CARE HOMES.**

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

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

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

73.8 ~~(d)~~ (c) "Health plan company" has the meaning provided in section 62Q.01, subdivision
73.9 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

76.20 (b) The ~~commissioners~~ commissioner shall establish an advisory committee that includes
76.21 representatives of the health care professions such as primary care providers₂, mental health
76.22 providers₂, nursing and care coordinators₂, certified health care home clinics with statewide
76.23 representation₂, health plan companies₂, state agencies₂, employers₂, academic researchers₂,
76.24 consumers₂, and organizations that work to improve health care quality in Minnesota. At
76.25 least 25 percent of the committee members must be consumers or patients in health care
76.26 homes. The ~~commissioners~~ commissioner, in making appointments to the committee, shall
76.27 ensure geographic representation of all regions of the state.

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

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

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

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

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

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

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

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

77.7 (d) The advisory committee shall have the ability to establish subcommittees on specific
77.8 topics. The advisory committee is governed by section 15.059. Notwithstanding section
77.9 15.059, the advisory committee does not expire.

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

77.11 Sec. 30. Minnesota Statutes 2018, section 256B.0753, subdivision 1, is amended to read:

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

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

77.28 Sec. 31. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision
77.29 to read:

77.30 **Subd. 6e. Dental services.** (a) If a dental provider is providing services to an enrollee
77.31 of a managed care plan or county-based purchasing plan based on a treatment plan that

78.1 requires more than one visit, the managed care plan or county-based purchasing plan or the
 78.2 plan's subcontractor, if the plan subcontracts with a third party to administer dental services
 78.3 to the plan's enrollees, must not require the completion of the treatment plan as a condition
 78.4 of payment to the dental provider for services performed as part of the treatment plan. The
 78.5 health plan or subcontractor must reimburse the dental provider for all services performed
 78.6 by the provider regardless of whether the treatment plan is completed, as long as the enrollee
 78.7 was covered under the plan at the time the service was performed.

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

78.13 Sec. 32. Minnesota Statutes 2018, section 256B.75, is amended to read:

78.14 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

78.15 (a) For outpatient hospital facility fee payments for services rendered on or after October
 78.16 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
 78.17 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
 78.18 which there is a federal maximum allowable payment. Effective for services rendered on
 78.19 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
 78.20 emergency room facility fees shall be increased by eight percent over the rates in effect on
 78.21 December 31, 1999, except for those services for which there is a federal maximum allowable
 78.22 payment. Services for which there is a federal maximum allowable payment shall be paid
 78.23 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
 78.24 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
 78.25 upper limit. If it is determined that a provision of this section conflicts with existing or
 78.26 future requirements of the United States government with respect to federal financial
 78.27 participation in medical assistance, the federal requirements prevail. The commissioner
 78.28 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
 78.29 participation resulting from rates that are in excess of the Medicare upper limitations.

78.30 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
 78.31 surgery hospital facility fee services for critical access hospitals designated under section
 78.32 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
 78.33 cost-finding methods and allowable costs of the Medicare program. Effective for services
 78.34 provided on or after July 1, 2015, rates established for critical access hospitals under this

79.1 paragraph for the applicable payment year shall be the final payment and shall not be settled
79.2 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
79.3 year ending in ~~2016~~ 2017, the rate for outpatient hospital services shall be computed using
79.4 information from each hospital's Medicare cost report as filed with Medicare for the year
79.5 that is two years before the year that the rate is being computed. Rates shall be computed
79.6 using information from Worksheet C series until the department finalizes the medical
79.7 assistance cost reporting process for critical access hospitals. After the cost reporting process
79.8 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
79.9 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
79.10 related to rural health clinics and federally qualified health clinics, divided by ancillary
79.11 charges plus outpatient charges, excluding charges related to rural health clinics and federally
79.12 qualified health clinics.

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

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

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

79.25 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
79.26 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
79.27 hospital facility services before third-party liability and spenddown, is reduced three percent
79.28 from the current statutory rates. Mental health services and facilities defined under section
79.29 256.969, subdivision 16, are excluded from this paragraph.

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

79.31 Sec. 33. Minnesota Statutes 2018, section 256L.03, subdivision 1, is amended to read:

79.32 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
79.33 services reimbursed under chapter 256B, with the exception of special education services,

80.1 home care nursing services, adult dental care services other than services covered under
80.2 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
80.3 services, personal care assistance and case management services, behavioral health home
80.4 services under section 256B.0757, and nursing home or intermediate care facilities services.

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

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

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

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

80.13 Sec. 34. Minnesota Statutes 2018, section 256L.15, subdivision 1, is amended to read:

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

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

80.22 (c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their
80.23 families shall have their premiums waived by the commissioner in accordance with section
80.24 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An
80.25 individual must indicate status as an American Indian, as defined under Code of Federal
80.26 Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The
80.27 commissioner shall accept attestation of an individual's status as an American Indian as
80.28 verification until the United States Department of Health and Human Services approves an
80.29 electronic data source for this purpose.

80.30 ~~(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting~~
80.31 ~~with the chairs and ranking minority members of the legislative committees with jurisdiction~~
80.32 ~~over human services, shall increase premiums under subdivision 2 for recipients based on~~
80.33 ~~June 2015 program enrollment. Premium increases shall be sufficient to increase projected~~

81.1 ~~revenue to the fund described in section 16A.724 by at least \$27,800,000 for the biennium~~
 81.2 ~~ending June 30, 2017. The commissioner shall publish the revised premium scale on the~~
 81.3 ~~Department of Human Services website and in the State Register no later than June 15,~~
 81.4 ~~2015. The revised premium scale applies to all premiums on or after August 1, 2015, in~~
 81.5 ~~place of the scale under subdivision 2.~~

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

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

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

81.15 Sec. 35. Laws 2019, chapter 63, article 3, section 1, is amended to read:

81.16 Section 1. **APPROPRIATIONS.**

81.17 (a) **Board of Pharmacy; administration.** \$244,000 in fiscal year 2020 is appropriated
 81.18 from the general fund to the Board of Pharmacy for onetime information technology and
 81.19 operating costs for administration of licensing activities under Minnesota Statutes, section
 81.20 151.066. This is a onetime appropriation.

81.21 (b) **Commissioner of human services; administration.** \$309,000 in fiscal year 2020
 81.22 is appropriated from the general fund and \$60,000 in fiscal year 2021 is appropriated from
 81.23 the opiate epidemic response ~~account~~ fund to the commissioner of human services for the
 81.24 provision of administrative services to the Opiate Epidemic Response Advisory Council
 81.25 and for the administration of the grants awarded under paragraphs (f), (g), and (h). The
 81.26 opiate epidemic response ~~account~~ fund base for this appropriation is \$60,000 in fiscal year
 81.27 2022, \$60,000 in fiscal year 2023, \$60,000 in fiscal year 2024, and \$0 in fiscal year 2025.

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

81.31 (d) **Commissioner of public safety; enforcement activities.** \$672,000 in fiscal year
 81.32 2020 is appropriated from the general fund to the commissioner of public safety for the

82.1 Bureau of Criminal Apprehension. Of this amount, \$384,000 is for drug scientists and lab
82.2 supplies and \$288,000 is for special agent positions focused on drug interdiction and drug
82.3 trafficking.

82.4 (e) **Commissioner of management and budget; evaluation activities.** \$300,000 in
82.5 fiscal year 2020 is appropriated from the general fund and \$300,000 in fiscal year 2021 is
82.6 appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of
82.7 management and budget for evaluation activities under Minnesota Statutes, section 256.042,
82.8 subdivision 1, paragraph (c). The opiate epidemic response ~~account~~ fund base for this
82.9 appropriation is \$300,000 in fiscal year 2022, \$300,000 in fiscal year 2023, \$300,000 in
82.10 fiscal year 2024, and \$0 in fiscal year 2025.

82.11 (f) **Commissioner of human services; grants for Project ECHO.** \$400,000 in fiscal
82.12 year 2020 is appropriated from the general fund and \$400,000 in fiscal year 2021 is
82.13 appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of human
82.14 services for grants of \$200,000 to CHI St. Gabriel's Health Family Medical Center for the
82.15 opioid-focused Project ECHO program and \$200,000 to Hennepin Health Care for the
82.16 opioid-focused Project ECHO program. The opiate epidemic response ~~account~~ fund base
82.17 for this appropriation is \$400,000 in fiscal year 2022, \$400,000 in fiscal year 2023, \$400,000
82.18 in fiscal year 2024, and \$0 in fiscal year 2025.

82.19 (g) **Commissioner of human services; opioid overdose prevention grant.** \$100,000
82.20 in fiscal year 2020 is appropriated from the general fund and \$100,000 in fiscal year 2021
82.21 is appropriated from the opiate epidemic response ~~account~~ fund to the commissioner of
82.22 human services for a grant to a nonprofit organization that has provided overdose prevention
82.23 programs to the public in at least 60 counties within the state, for at least three years, has
82.24 received federal funding before January 1, 2019, and is dedicated to addressing the opioid
82.25 epidemic. The grant must be used for opioid overdose prevention, community asset mapping,
82.26 education, and overdose antagonist distribution. The opiate epidemic response ~~account~~ fund
82.27 base for this appropriation is \$100,000 in fiscal year 2022, \$100,000 in fiscal year 2023,
82.28 \$100,000 in fiscal year 2024, and \$0 in fiscal year 2025.

82.29 (h) **Commissioner of human services; traditional healing.** \$2,000,000 in fiscal year
82.30 2020 is appropriated from the general fund and \$2,000,000 in fiscal year 2021 is appropriated
82.31 from the opiate epidemic response ~~account~~ fund to the commissioner of human services to
82.32 award grants to tribal nations and five urban Indian communities for traditional healing
82.33 practices to American Indians and to increase the capacity of culturally specific providers
82.34 in the behavioral health workforce. The opiate epidemic response ~~account~~ fund base for

83.1 this appropriation is \$2,000,000 in fiscal year 2022, \$2,000,000 in fiscal year 2023,
83.2 \$2,000,000 in fiscal year 2024, and \$0 in fiscal year 2025.

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

83.7 (j) **Board of Medical Practice; continuing education.** \$17,000 in fiscal year 2020 is
83.8 appropriated from the state government special revenue fund to the Board of Medical Practice
83.9 to implement the continuing education requirements under Minnesota Statutes, section
83.10 214.12, subdivision 6.

83.11 (k) **Board of Nursing; continuing education.** \$17,000 in fiscal year 2020 is appropriated
83.12 from the state government special revenue fund to the Board of Nursing to implement the
83.13 continuing education requirements under Minnesota Statutes, section 214.12, subdivision
83.14 6.

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

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

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

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

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

83.31 The demonstration projects must include an evaluation component and scalability analysis.
83.32 The commissioner shall award the grant for the statewide mapping and assessment, and the
83.33 demonstration project grants, through a competitive request for proposal process. Grants

84.1 for statewide mapping and assessment and demonstration projects may be awarded
 84.2 simultaneously. In awarding demonstration project grants, the commissioner shall give
 84.3 preference to proposals that incorporate innovative community partnerships, are informed
 84.4 and led by people in the community where the project is taking place, and are culturally
 84.5 relevant and delivered by culturally competent providers. This is a onetime appropriation.

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

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

84.10 Sec. 36. Laws 2019, chapter 63, article 3, section 2, is amended to read:

84.11 Sec. 2. **TRANSFER.**

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

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

84.15 Sec. 37. Laws 2020, chapter 73, section 4, subdivision 3, is amended to read:

84.16 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form
 84.17 to be used by an individual who is in urgent need of insulin. The application must ask the
 84.18 individual to attest to the eligibility requirements described in subdivision 2. The form shall
 84.19 be accessible through MNsure's website. MNsure shall also make the form available to
 84.20 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency
 84.21 departments, urgent care clinics, and community health clinics. By submitting a completed,
 84.22 signed, and dated application to a pharmacy, the individual attests that the information
 84.23 contained in the application is correct.

84.24 (b) If the individual is in urgent need of insulin, the individual may present a completed,
 84.25 signed, and dated application form to a pharmacy. The individual must also:

84.26 (1) have a valid insulin prescription; and

84.27 (2) present the pharmacist with identification indicating Minnesota residency in the form
 84.28 of a valid Minnesota identification card, driver's license, or permit, or tribal identification
 84.29 card as defined in section 171.072, paragraph (b). If the individual in urgent need of insulin
 84.30 is under the age of 18, the individual's parent or legal guardian must provide the pharmacist
 84.31 with proof of residency.

85.1 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense
85.2 the prescribed insulin in an amount that will provide the individual with a 30-day supply.
85.3 The pharmacy must notify the health care practitioner who issued the prescription order no
85.4 later than 72 hours after the insulin is dispensed.

85.5 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
85.6 to the manufacturer's vendor a claim for payment that is in accordance with the National
85.7 Council for Prescription Drug Program standards for electronic claims processing, unless
85.8 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin
85.9 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the
85.10 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the
85.11 pharmacy in an amount that covers the pharmacy's acquisition cost.

85.12 (e) The pharmacy may collect an insulin co-payment from the individual to cover the
85.13 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day
85.14 supply of insulin dispensed.

85.15 (f) The pharmacy shall also provide each eligible individual with the information sheet
85.16 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy
85.17 for the individual to contact if the individual is in need of accessing ongoing insulin coverage
85.18 options, including assistance in:

85.19 (1) applying for medical assistance or MinnesotaCare;

85.20 (2) applying for a qualified health plan offered through MNsure, subject to open and
85.21 special enrollment periods;

85.22 (3) accessing information on providers who participate in prescription drug discount
85.23 programs, including providers who are authorized to participate in the 340B program under
85.24 section 340b of the federal Public Health Services Act, United States Code, title 42, section
85.25 256b; and

85.26 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance
85.27 programs, and other foundation-based programs.

85.28 (g) The pharmacist shall retain a copy of the application form submitted by the individual
85.29 to the pharmacy for reporting and auditing purposes.

85.30 Sec. 38. Laws 2020, chapter 73, section 4, subdivision 4, is amended to read:

85.31 Subd. 4. **Continuing safety net program; general.** (a) Each manufacturer shall make
85.32 a patient assistance program available to any individual who meets the requirements of this

86.1 subdivision. Each manufacturer's patient assistance programs must meet the requirements
86.2 of this section. Each manufacturer shall provide the Board of Pharmacy with information
86.3 regarding the manufacturer's patient assistance program, including contact information for
86.4 individuals to call for assistance in accessing their patient assistance program.

86.5 (b) To be eligible to participate in a manufacturer's patient assistance program, the
86.6 individual must:

86.7 (1) be a Minnesota resident with a valid Minnesota identification card that indicates
86.8 Minnesota residency in the form of a Minnesota identification card ~~or~~, driver's license or
86.9 permit, or tribal identification card as defined in section 171.072, paragraph (b). If the
86.10 individual is under the age of 18, the individual's parent or legal guardian must provide
86.11 proof of residency;

86.12 (2) have a family income that is equal to or less than 400 percent of the federal poverty
86.13 guidelines;

86.14 (3) not be enrolled in medical assistance or MinnesotaCare;

86.15 (4) not be eligible to receive health care through a federally funded program or receive
86.16 prescription drug benefits through the Department of Veterans Affairs; and

86.17 (5) not be enrolled in prescription drug coverage through an individual or group health
86.18 plan that limits the total amount of cost-sharing that an enrollee is required to pay for a
86.19 30-day supply of insulin, including co-payments, deductibles, or coinsurance to \$75 or less,
86.20 regardless of the type or amount of insulin needed.

86.21 (c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is
86.22 enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if
86.23 the individual has spent \$1,000 on prescription drugs in the current calendar year and meets
86.24 the eligibility requirements in paragraph (b), clauses (1) to (3).

86.25 (d) An individual who is interested in participating in a manufacturer's patient assistance
86.26 program may apply directly to the manufacturer; apply through the individual's health care
86.27 practitioner, if the practitioner participates; or contact a trained navigator for assistance in
86.28 finding a long-term insulin supply solution, including assistance in applying to a
86.29 manufacturer's patient assistance program.

87.1 Sec. 39. **REVISOR INSTRUCTION.**

87.2 (a) The revisor of statutes shall number the existing language in Minnesota Statutes,
 87.3 section 62U.03, as subdivision 1 and renumber the provisions of Minnesota Statutes listed
 87.4 in column A to the references listed in column B.

87.5	<u>Column A</u>	<u>Column B</u>
87.6	<u>256B.0751, subdivision 1</u>	<u>62U.03, subdivision 2</u>
87.7	<u>256B.0751, subdivision 2</u>	<u>62U.03, subdivision 3</u>
87.8	<u>256B.0751, subdivision 3</u>	<u>62U.03, subdivision 4</u>
87.9	<u>256B.0751, subdivision 4</u>	<u>62U.03, subdivision 5</u>
87.10	<u>256B.0751, subdivision 5</u>	<u>62U.03, subdivision 6</u>
87.11	<u>256B.0751, subdivision 6</u>	<u>62U.03, subdivision 7</u>
87.12	<u>256B.0751, subdivision 7</u>	<u>62U.03, subdivision 8</u>
87.13	<u>256B.0751, subdivision 8</u>	<u>62U.03, subdivision 9</u>
87.14	<u>256B.0751, subdivision 9</u>	<u>62U.03, subdivision 10</u>
87.15	<u>256B.0751, subdivision 10</u>	<u>62U.03, subdivision 11</u>

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

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

87.22 Sec. 40. **REPEALER.**

87.23 Minnesota Statutes 2018, sections 62U.15, subdivision 2; 256B.057, subdivision 8;
 87.24 256B.0752; and 256L.04, subdivision 13, are repealed.

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

87.26 **ARTICLE 4**87.27 **ADVANCED PRACTICE REGISTERED NURSE PROVISIONS**

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

87.29 Subdivision 1. **Marketing requirements.** (a) Any written marketing materials which
 87.30 may be directed toward potential enrollees and which include a detailed description of
 87.31 benefits provided by the health maintenance organization shall include a statement of enrollee
 87.32 information and rights as described in section 62D.07, subdivision 3, clauses (2) and (3).

88.1 Prior to any oral marketing presentation, the agent marketing the plan must inform the
88.2 potential enrollees that any complaints concerning the material presented should be directed
88.3 to the health maintenance organization, the commissioner of health, or, if applicable, the
88.4 employer.

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

88.8 (1) health care services not provided;

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

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

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

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

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

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

88.25 Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a
88.26 number three qualified plan if it otherwise meets the requirements established by chapters
88.27 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in
88.28 Minnesota, and meets or exceeds the following minimum standards:

88.29 (a) The minimum benefits for a covered individual shall, subject to the other provisions
88.30 of this subdivision, be equal to at least 80 percent of the cost of covered services in excess
88.31 of an annual deductible which does not exceed \$150 per person. The coverage shall include
88.32 a limitation of \$3,000 per person on total annual out-of-pocket expenses for services covered

89.1 under this subdivision. The coverage shall not be subject to a lifetime maximum on essential
89.2 health benefits.

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

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

89.8 (1) hospital services;

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

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

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

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

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

89.18 (7) oxygen;

89.19 (8) anesthetics;

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

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

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

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

89.28 (13) services of a physical therapist;

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

90.1 (15) services of an occupational therapist.

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

90.4 (1) any charge for care for injury or disease either (i) arising out of an injury in the course
90.5 of employment and subject to a workers' compensation or similar law, (ii) for which benefits
90.6 are payable without regard to fault under coverage statutorily required to be contained in
90.7 any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii)
90.8 for which benefits are payable under another policy of accident and health insurance,
90.9 Medicare, or any other governmental program except as otherwise provided by section
90.10 62A.04, subdivision 3, clause (4);

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

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

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

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

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

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

90.31 (e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in
90.32 addition to those benefits specified in clause (a), a second opinion from a physician on all
90.33 surgical procedures expected to cost a total of \$500 or more in physician, laboratory, and

91.1 hospital fees, provided that the coverage need not include the repetition of any diagnostic
91.2 tests.

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

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

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

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

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

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

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

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

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

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

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

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

92.3 Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner
92.4 under this section, the restrictions in the federal Medicare antikickback statutes in section
92.5 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and
92.6 rules adopted under the federal statutes, apply to all persons in the state, regardless of whether
92.7 the person participates in any state health care program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

93.31 (1) provide clinical decision support;

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

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

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

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

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

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

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

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

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

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

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

95.3 (2) at least one of the following:

95.4 (i) the specific diagnostic-related group code;

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

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

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

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

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

95.13 (b) "Clinical practice guideline" means a systematically developed statement to assist
95.14 health care providers and enrollees in making decisions about appropriate health care services
95.15 for specific clinical circumstances and conditions developed independently of a health plan
95.16 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical
95.17 practice guideline also includes a preferred drug list developed in accordance with section
95.18 256B.0625.

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

95.22 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but
95.23 also includes a county-based purchasing plan participating in a public program under chapter
95.24 256B or 256L and an integrated health partnership under section 256B.0755.

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

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

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

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

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

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

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

96.17 **62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.**

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

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

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

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

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

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

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

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

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

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

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

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

97.19 (c) For an external review of any issue in an adverse determination by a health plan
97.20 company, other than a health plan company licensed under chapter 62D, that requires a
97.21 medical necessity determination, the external review must determine whether the adverse
97.22 determination was consistent with the definition of medically necessary care in section
97.23 62Q.53, subdivision 2.

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

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

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

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

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

98.9 (1) health;

98.10 (2) no-fault automobile medical benefits; or

98.11 (3) workers' compensation medical benefits.

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

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

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

98.18 COMPANY NAME

98.19 ADDRESS - CITY AND STATE

98.20 TELEPHONE NUMBER

98.21 LONG-TERM CARE INSURANCE

98.22 OUTLINE OF COVERAGE

98.23 Policy Number or Group Master Policy and Certificate Number

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

100.31 (9) BENEFITS PROVIDED BY THIS POLICY.

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

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

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

101.5 (d) (Eligibility for payment of benefits.)

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

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

101.14 (10) LIMITATIONS AND EXCLUSIONS:

101.15 Describe:

101.16 (a) preexisting conditions;

101.17 (b) noneligible facilities/provider;

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

101.20 (d) exclusions/exceptions; and

101.21 (e) limitations.

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

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

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

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

102.1 (b) any automatic benefit adjustment provisions;

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

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

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

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

102.15 (13) PREMIUM.

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

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

102.19 (14) ADDITIONAL FEATURES.

102.20 (a) Indicate if medical underwriting is used.

102.21 (b) Describe other important features.

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

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

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

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

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

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

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

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

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

103.21 (b) "Chronically ill individual" has the meaning prescribed for this term by section
103.22 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a
103.23 chronically ill individual means any individual who has been certified by a licensed health
103.24 care practitioner as being unable to perform, without substantial assistance from another
103.25 individual, at least two activities of daily living for a period of at least 90 days due to a loss
103.26 of functional capacity, or requiring substantial supervision to protect the individual from
103.27 threats to health and safety due to severe cognitive impairment.

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

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

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

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

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

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

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

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

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

104.17 (2) hospitals eligible for rural hospital capital improvement grants, as defined in section
104.18 144.148;

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

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

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

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

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

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

105.2 **144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT**
105.3 **IMMUNIZATION.**

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

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

105.8 **144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.**

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

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

106.2 Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision
106.3 2, a person employed by the designated school or school district shall submit to the
106.4 administrator or other person having general control and supervision of the school one of
106.5 the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

107.17 (3) the manner by which tuberculosis is transmitted;

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

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

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

107.21 (7) that screening has been scheduled; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

109.19 **144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

116.18 (3) periodically, in consultation with the resident, the family, and the attending physician
116.19 or advanced practice registered nurse, reevaluate the resident's need for the restraint.

116.20 (d) A nursing home shall not be subject to fines, civil money penalties, or other state or
116.21 federal survey enforcement remedies solely as the result of allowing the use of a physical
116.22 restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the
116.23 commissioner from taking action to protect the health and safety of a resident if:

116.24 (1) the use of the restraint has jeopardized the health and safety of the resident; and

116.25 (2) the nursing home failed to take reasonable measures to protect the health and safety
116.26 of the resident.

116.27 (e) For purposes of this subdivision, "medical symptoms" include:

116.28 (1) a concern for the physical safety of the resident; and

116.29 (2) physical or psychological needs expressed by a resident. A resident's fear of falling
116.30 may be the basis of a medical symptom.

117.1 A written order from the attending physician or advanced practice registered nurse that
117.2 contains statements and determinations regarding medical symptoms is sufficient evidence
117.3 of the medical necessity of the physical restraint.

117.4 (f) When determining nursing facility compliance with state and federal standards for
117.5 the use of physical restraints, the commissioner of health is bound by the statements and
117.6 determinations contained in the attending physician's or advanced practice registered nurse's
117.7 order regarding medical symptoms. For purposes of this order, "medical symptoms" include
117.8 the request by a competent resident, family member of a resident who is not competent, or
117.9 legally appointed conservator, guardian, or health care agent as defined under section
117.10 145C.01, that the facility provide a physical restraint in order to enhance the physical safety
117.11 of the resident.

117.12 Sec. 46. Minnesota Statutes 2018, section 144.652, subdivision 2, is amended to read:

117.13 Subd. 2. **Correction order; emergencies.** A substantial violation of the rights of any
117.14 patient or resident as defined in section 144.651, shall be grounds for issuance of a correction
117.15 order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction
117.16 order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf
117.17 of a patient or resident to enforce any unreasonable violation of the patient's or resident's
117.18 rights. Compliance with the provisions of section 144.651 shall not be required whenever
117.19 emergency conditions, as documented by the attending physician or advanced practice
117.20 registered nurse in a patient's medical record or a resident's care record, indicate immediate
117.21 medical treatment, including but not limited to surgical procedures, is necessary and it is
117.22 impossible or impractical to comply with the provisions of section 144.651 because delay
117.23 would endanger the patient's or resident's life, health, or safety.

117.24 Sec. 47. Minnesota Statutes 2018, section 144.69, is amended to read:

117.25 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

117.26 Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data
117.27 collected on individuals by the cancer surveillance system, including the names and personal
117.28 identifiers of persons required in section 144.68 to report, shall be private and may only be
117.29 used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68.
117.30 Any disclosure other than is provided for in this section and sections 144.671, 144.672, and
117.31 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by
117.32 rule, and as part of an epidemiologic investigation, an officer or employee of the
117.33 commissioner of health may interview patients named in any such report, or relatives of

118.1 any such patient, only after the consent of the attending physician, advanced practice
118.2 registered nurse, or surgeon is obtained.

118.3 Sec. 48. Minnesota Statutes 2018, section 144.7402, subdivision 2, is amended to read:

118.4 Subd. 2. **Conditions.** A facility shall follow the procedures outlined in sections 144.7401
118.5 to 144.7415 when all of the following conditions are met:

118.6 (1) the facility determines that significant exposure has occurred, following the protocol
118.7 under section 144.7414;

118.8 (2) the licensed physician or advanced practice registered nurse for the emergency
118.9 medical services person needs the source individual's blood-borne pathogen test results to
118.10 begin, continue, modify, or discontinue treatment, in accordance with the most current
118.11 guidelines of the United States Public Health Service, because of possible exposure to a
118.12 blood-borne pathogen; and

118.13 (3) the emergency medical services person consents to provide a blood sample for testing
118.14 for a blood-borne pathogen. If the emergency medical services person consents to blood
118.15 collection, but does not consent at that time to blood-borne pathogen testing, the facility
118.16 shall preserve the sample for at least 90 days. If the emergency medical services person
118.17 elects to have the sample tested within 90 days, the testing shall be done as soon as feasible.

118.18 Sec. 49. Minnesota Statutes 2018, section 144.7406, subdivision 2, is amended to read:

118.19 Subd. 2. **Procedures without consent.** If the source individual has provided a blood
118.20 sample with consent but does not consent to blood-borne pathogen testing, the facility shall
118.21 test for blood-borne pathogens if the emergency medical services person or emergency
118.22 medical services agency requests the test, provided all of the following criteria are met:

118.23 (1) the emergency medical services person or emergency medical services agency has
118.24 documented exposure to blood or body fluids during performance of that person's occupation
118.25 or while acting as a Good Samaritan under section 604A.01 or executing a citizen's arrest
118.26 under section 629.30;

118.27 (2) the facility has determined that a significant exposure has occurred and a licensed
118.28 physician or advanced practice registered nurse for the emergency medical services person
118.29 has documented in the emergency medical services person's medical record that blood-borne
118.30 pathogen test results are needed for beginning, modifying, continuing, or discontinuing
118.31 medical treatment for the emergency medical services person under section 144.7414,
118.32 subdivision 2;

119.1 (3) the emergency medical services person provides a blood sample for testing for
119.2 blood-borne pathogens as soon as feasible;

119.3 (4) the facility asks the source individual to consent to a test for blood-borne pathogens
119.4 and the source individual does not consent;

119.5 (5) the facility has provided the source individual with all of the information required
119.6 by section 144.7403; and

119.7 (6) the facility has informed the emergency medical services person of the confidentiality
119.8 requirements of section 144.7411 and the penalties for unauthorized release of source
119.9 information under section 144.7412.

119.10 Sec. 50. Minnesota Statutes 2018, section 144.7407, subdivision 2, is amended to read:

119.11 Subd. 2. **Procedures without consent.** (a) An emergency medical services agency, or,
119.12 if there is no agency, an emergency medical services person, may bring a petition for a court
119.13 order to require a source individual to provide a blood sample for testing for blood-borne
119.14 pathogens. The petition shall be filed in the district court in the county where the source
119.15 individual resides or is hospitalized. The petitioner shall serve the petition on the source
119.16 individual at least three days before a hearing on the petition. The petition shall include one
119.17 or more affidavits attesting that:

119.18 (1) the facility followed the procedures in sections 144.7401 to 144.7415 and attempted
119.19 to obtain blood-borne pathogen test results according to those sections;

119.20 (2) it has been determined under section 144.7414, subdivision 2, that a significant
119.21 exposure has occurred to the emergency medical services person; and

119.22 (3) a physician with specialty training in infectious diseases, including HIV, has
119.23 documented that the emergency medical services person has provided a blood sample and
119.24 consented to testing for blood-borne pathogens and blood-borne pathogen test results are
119.25 needed for beginning, continuing, modifying, or discontinuing medical treatment for the
119.26 emergency medical services person.

119.27 (b) Facilities shall cooperate with petitioners in providing any necessary affidavits to
119.28 the extent that facility staff can attest under oath to the facts in the affidavits.

119.29 (c) The court may order the source individual to provide a blood sample for blood-borne
119.30 pathogen testing if:

119.31 (1) there is probable cause to believe the emergency medical services person has
119.32 experienced a significant exposure to the source individual;

120.1 (2) the court imposes appropriate safeguards against unauthorized disclosure that must
120.2 specify the persons who have access to the test results and the purposes for which the test
120.3 results may be used;

120.4 (3) a licensed physician or advanced practice registered nurse for the emergency medical
120.5 services person needs the test results for beginning, continuing, modifying, or discontinuing
120.6 medical treatment for the emergency medical services person; and

120.7 (4) the court finds a compelling need for the test results. In assessing compelling need,
120.8 the court shall weigh the need for the court-ordered blood collection and test results against
120.9 the interests of the source individual, including, but not limited to, privacy, health, safety,
120.10 or economic interests. The court shall also consider whether the involuntary blood collection
120.11 and testing would serve the public interest.

120.12 (d) The court shall conduct the proceeding in camera unless the petitioner or the source
120.13 individual requests a hearing in open court and the court determines that a public hearing
120.14 is necessary to the public interest and the proper administration of justice.

120.15 (e) The court shall conduct an ex parte hearing if the source individual does not attend
120.16 the noticed hearing and the petitioner complied with the notice requirements in paragraph
120.17 (a).

120.18 (f) The source individual has the right to counsel in any proceeding brought under this
120.19 subdivision.

120.20 (g) The court may order a source individual taken into custody by a peace officer for
120.21 purposes of obtaining a blood sample if the source individual does not comply with an order
120.22 issued by the court pursuant to paragraph (c). The source individual shall be held no longer
120.23 than is necessary to secure a blood sample. A person may not be held for more than 24 hours
120.24 without receiving a court hearing.

120.25 Sec. 51. Minnesota Statutes 2018, section 144.7414, subdivision 2, is amended to read:

120.26 Subd. 2. **Facility protocol requirements.** Every facility shall adopt and follow a
120.27 postexposure protocol for emergency medical services persons who have experienced a
120.28 significant exposure. The postexposure protocol must adhere to the most current
120.29 recommendations of the United States Public Health Service and include, at a minimum,
120.30 the following:

120.31 (1) a process for emergency medical services persons to report an exposure in a timely
120.32 fashion;

121.1 (2) a process for an infectious disease specialist, or a licensed physician or advanced
 121.2 practice registered nurse who is knowledgeable about the most current recommendations
 121.3 of the United States Public Health Service in consultation with an infectious disease specialist,
 121.4 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
 121.5 occurred and (ii) to provide, under the direction of a licensed physician or advanced practice
 121.6 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
 121.7 to the particular blood-borne pathogen or pathogens for which a significant exposure has
 121.8 been determined;

121.9 (3) if there has been a significant exposure, a process to determine whether the source
 121.10 individual has a blood-borne pathogen through disclosure of test results, or through blood
 121.11 collection and testing as required by sections 144.7401 to 144.7415;

121.12 (4) a process for providing appropriate counseling prior to and following testing for a
 121.13 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
 121.14 follow-up recommendations according to the most current recommendations of the United
 121.15 States Public Health Service, recommendations for testing, and treatment to the emergency
 121.16 medical services person;

121.17 (5) a process for providing appropriate counseling under clause (4) to the emergency
 121.18 medical services person and the source individual; and

121.19 (6) compliance with applicable state and federal laws relating to data practices,
 121.20 confidentiality, informed consent, and the patient bill of rights.

121.21 Sec. 52. Minnesota Statutes 2018, section 144.7415, subdivision 2, is amended to read:

121.22 Subd. 2. **Immunity.** A facility, licensed physician, advanced practice registered nurse,
 121.23 and designated health care personnel are immune from liability in any civil, administrative,
 121.24 or criminal action relating to the disclosure of test results to an emergency medical services
 121.25 person or emergency medical services agency and the testing of a blood sample from the
 121.26 source individual for blood-borne pathogens if a good faith effort has been made to comply
 121.27 with sections 144.7401 to 144.7415.

121.28 Sec. 53. Minnesota Statutes 2018, section 144.9502, subdivision 4, is amended to read:

121.29 Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis
 121.30 reports required in this section must specify:

121.31 (1) whether the specimen was collected as a capillary or venous sample;

121.32 (2) the date the sample was collected;

- 122.1 (3) the results of the blood lead analysis;
- 122.2 (4) the date the sample was analyzed;
- 122.3 (5) the method of analysis used;
- 122.4 (6) the full name, address, and phone number of the laboratory performing the analysis;
- 122.5 (7) the full name, address, and phone number of the physician, advanced practice
- 122.6 registered nurse, or facility requesting the analysis;
- 122.7 (8) the full name, address, and phone number of the person with the blood lead level,
- 122.8 and the person's birthdate, gender, and race.
- 122.9 Sec. 54. Minnesota Statutes 2018, section 144.966, subdivision 3, is amended to read:
- 122.10 Subd. 3. **Early hearing detection and intervention programs.** All hospitals shall
- 122.11 establish an early hearing detection and intervention (EHDI) program. Each EHDI program
- 122.12 shall:
- 122.13 (1) in advance of any hearing screening testing, provide to the newborn's or infant's
- 122.14 parents or parent information concerning the nature of the screening procedure, applicable
- 122.15 costs of the screening procedure, the potential risks and effects of hearing loss, and the
- 122.16 benefits of early detection and intervention;
- 122.17 (2) comply with parental election as described under section 144.125, subdivision 4;
- 122.18 (3) develop policies and procedures for screening and rescreening based on Department
- 122.19 of Health recommendations;
- 122.20 (4) provide appropriate training and monitoring of individuals responsible for performing
- 122.21 hearing screening tests as recommended by the Department of Health;
- 122.22 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain
- 122.23 in the hospital for a prolonged period, testing shall be performed prior to three months of
- 122.24 age or when medically feasible;
- 122.25 (6) develop and implement procedures for documenting the results of all hearing screening
- 122.26 tests;
- 122.27 (7) inform the newborn's or infant's parents or parent, primary care physician or advanced
- 122.28 practice registered nurse, and the Department of Health according to recommendations of
- 122.29 the Department of Health of the results of the hearing screening test or rescreening if
- 122.30 conducted, or if the newborn or infant was not successfully tested. The hospital that
- 122.31 discharges the newborn or infant to home is responsible for the screening; and

123.1 (8) collect performance data specified by the Department of Health.

123.2 Sec. 55. Minnesota Statutes 2018, section 144.966, subdivision 6, is amended to read:

123.3 Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician, advanced
123.4 practice registered nurse, or hospital shall be civilly or criminally liable for failure to conduct
123.5 hearing screening testing.

123.6 (b) No physician, midwife, nurse, other health professional, or hospital acting in
123.7 compliance with this section shall be civilly or criminally liable for any acts conforming
123.8 with this section, including furnishing information required according to this section.

123.9 Sec. 56. Minnesota Statutes 2018, section 144A.135, is amended to read:

123.10 **144A.135 TRANSFER AND DISCHARGE APPEALS.**

123.11 (a) The commissioner shall establish a mechanism for hearing appeals on transfers and
123.12 discharges of residents by nursing homes or boarding care homes licensed by the
123.13 commissioner. The commissioner may adopt permanent rules to implement this section.

123.14 (b) Until federal regulations are adopted under sections 1819(f)(3) and 1919(f)(3) of the
123.15 Social Security Act that govern appeals of the discharges or transfers of residents from
123.16 nursing homes and boarding care homes certified for participation in Medicare or medical
123.17 assistance, the commissioner shall provide hearings under sections 14.57 to 14.62 and the
123.18 rules adopted by the Office of Administrative Hearings governing contested cases. To appeal
123.19 the discharge or transfer, or notification of an intended discharge or transfer, a resident or
123.20 the resident's representative must request a hearing in writing no later than 30 days after
123.21 receiving written notice, which conforms to state and federal law, of the intended discharge
123.22 or transfer.

123.23 (c) Hearings under this section shall be held no later than 14 days after receipt of the
123.24 request for hearing, unless impractical to do so or unless the parties agree otherwise. Hearings
123.25 shall be held in the facility in which the resident resides, unless impractical to do so or unless
123.26 the parties agree otherwise.

123.27 (d) A resident who timely appeals a notice of discharge or transfer, and who resides in
123.28 a certified nursing home or boarding care home, may not be discharged or transferred by
123.29 the nursing home or boarding care home until resolution of the appeal. The commissioner
123.30 can order the facility to readmit the resident if the discharge or transfer was in violation of
123.31 state or federal law. If the resident is required to be hospitalized for medical necessity before
123.32 resolution of the appeal, the facility shall readmit the resident unless the resident's attending

124.1 physician or advanced practice registered nurse documents, in writing, why the resident's
124.2 specific health care needs cannot be met in the facility.

124.3 (e) The commissioner and Office of Administrative Hearings shall conduct the hearings
124.4 in compliance with the federal regulations described in paragraph (b), when adopted.

124.5 (f) Nothing in this section limits the right of a resident or the resident's representative
124.6 to request or receive assistance from the Office of Ombudsman for Long-Term Care or the
124.7 Office of Health Facility Complaints with respect to an intended discharge or transfer.

124.8 (g) A person required to inform a health care facility of the person's status as a registered
124.9 predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so
124.10 shall be deemed to have endangered the safety of individuals in the facility under Code of
124.11 Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal
124.12 of the notice and discharge shall not constitute a stay of the discharge.

124.13 Sec. 57. Minnesota Statutes 2018, section 144A.161, subdivision 5, is amended to read:

124.14 Subd. 5. **Licensee responsibilities related to sending the notice in subdivision 5a.** (a)
124.15 The licensee shall establish an interdisciplinary team responsible for coordinating and
124.16 implementing the plan. The interdisciplinary team shall include representatives from the
124.17 county social services agency, the Office of Ombudsman for Long-Term Care, the Office
124.18 of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that
124.19 provide direct care services to the residents, and facility administration.

124.20 (b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide an
124.21 updated resident census summary document to the county social services agency, the
124.22 Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental
124.23 Disabilities that includes the following information on each resident to be relocated:

124.24 (1) resident name;

124.25 (2) date of birth;

124.26 (3) Social Security number;

124.27 (4) payment source and medical assistance identification number, if applicable;

124.28 (5) county of financial responsibility if the resident is enrolled in a Minnesota health
124.29 care program;

124.30 (6) date of admission to the facility;

124.31 (7) all current diagnoses;

125.1 (8) the name of and contact information for the resident's physician or advanced practice
 125.2 registered nurse;

125.3 (9) the name and contact information for the resident's responsible party;

125.4 (10) the name of and contact information for any case manager, managed care coordinator,
 125.5 or other care coordinator, if known;

125.6 (11) information on the resident's status related to commitment and probation; and

125.7 (12) the name of the managed care organization in which the resident is enrolled, if
 125.8 known.

125.9 Sec. 58. Minnesota Statutes 2018, section 144A.161, subdivision 5a, is amended to read:

125.10 Subd. 5a. **Administrator and licensee responsibility to provide notice.** At least 60
 125.11 days before the proposed date of closing, reduction, or change in operations as agreed to in
 125.12 the plan, the administrator shall send a written notice of closure, reduction, or change in
 125.13 operations to each resident being relocated, the resident's responsible party, the resident's
 125.14 managed care organization if it is known, the county social services agency, the commissioner
 125.15 of health, the commissioner of human services, the Office of Ombudsman for Long-Term
 125.16 Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the
 125.17 resident's attending physician or advanced practice registered nurse, and, in the case of a
 125.18 complete facility closure, the Centers for Medicare and Medicaid Services regional office
 125.19 designated representative. The notice must include the following:

125.20 (1) the date of the proposed closure, reduction, or change in operations;

125.21 (2) the contact information of the individual or individuals in the facility responsible for
 125.22 providing assistance and information;

125.23 (3) notification of upcoming meetings for residents, responsible parties, and resident
 125.24 and family councils to discuss the plan for relocation of residents;

125.25 (4) the contact information of the county social services agency contact person; and

125.26 (5) the contact information of the Office of Ombudsman for Long-Term Care and the
 125.27 Office of Ombudsman for Mental Health and Developmental Disabilities.

125.28 Sec. 59. Minnesota Statutes 2018, section 144A.161, subdivision 5e, is amended to read:

125.29 Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents
 125.30 desiring to make site visits to facilities with available beds or other appropriate living options
 125.31 to which the resident may relocate, unless it is medically inadvisable, as documented by

126.1 the attending physician or advanced practice registered nurse in the resident's care record.
126.2 The licensee shall make available to the resident at no charge transportation for up to three
126.3 site visits to facilities or other living options within the county or contiguous counties.

126.4 Sec. 60. Minnesota Statutes 2018, section 144A.161, subdivision 5g, is amended to read:

126.5 Subd. 5g. **Licensee responsibilities for final written discharge notice and records**
126.6 **transfer.** (a) The licensee shall provide the resident, the resident's responsible parties, the
126.7 resident's managed care organization, if known, and the resident's attending physician or
126.8 advanced practice registered nurse with a final written discharge notice prior to the relocation
126.9 of the resident. The notice must:

126.10 (1) be provided prior to the actual relocation; and

126.11 (2) identify the effective date of the anticipated relocation and the destination to which
126.12 the resident is being relocated.

126.13 (b) The licensee shall provide the receiving facility or other health, housing, or care
126.14 entity with complete and accurate resident records including contact information for family
126.15 members, responsible parties, social service or other caseworkers, and managed care
126.16 coordinators. These records must also include all information necessary to provide appropriate
126.17 medical care and social services. This includes, but is not limited to, information on
126.18 preadmission screening, Level I and Level II screening, minimum data set (MDS), all other
126.19 assessments, current resident diagnoses, social, behavioral, and medication information,
126.20 required forms, and discharge summaries.

126.21 (c) For residents with special care needs, the licensee shall consult with the receiving
126.22 facility or other placement entity and provide staff training or other preparation as needed
126.23 to assist in providing for the special needs.

126.24 Sec. 61. Minnesota Statutes 2018, section 144A.75, subdivision 3, is amended to read:

126.25 Subd. 3. **Core services.** "Core services" means physician services, registered nursing
126.26 services, advanced practice registered nurse services, medical social services, and counseling
126.27 services. A hospice must ensure that at least two core services are regularly provided directly
126.28 by hospice employees. A hospice provider may use contracted staff if necessary to
126.29 supplement hospice employees in order to meet the needs of patients during peak patient
126.30 loads or under extraordinary circumstances.

127.1 Sec. 62. Minnesota Statutes 2018, section 144A.75, subdivision 6, is amended to read:

127.2 Subd. 6. **Hospice patient.** "Hospice patient" means an individual whose illness has been
127.3 documented by the individual's attending physician or advanced practice registered nurse
127.4 and hospice medical director, who alone or, when unable, through the individual's family
127.5 has voluntarily consented to and received admission to a hospice provider, and who:

127.6 (1) has been diagnosed as terminally ill, with a probable life expectancy of under one
127.7 year; or

127.8 (2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and
127.9 life-threatening illness contributing to a shortened life expectancy; and is not expected to
127.10 survive to adulthood.

127.11 Sec. 63. Minnesota Statutes 2018, section 144A.752, subdivision 1, is amended to read:

127.12 Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of hospice
127.13 providers according to sections 144A.75 to 144A.755. The rules shall include the following:

127.14 (1) provisions to ensure, to the extent possible, the health, safety, well-being, and
127.15 appropriate treatment of persons who receive hospice care;

127.16 (2) requirements that hospice providers furnish the commissioner with specified
127.17 information necessary to implement sections 144A.75 to 144A.755;

127.18 (3) standards of training of hospice provider personnel;

127.19 (4) standards for medication management, which may vary according to the nature of
127.20 the hospice care provided, the setting in which the hospice care is provided, or the status of
127.21 the patient;

127.22 (5) standards for hospice patient and hospice patient's family evaluation or assessment,
127.23 which may vary according to the nature of the hospice care provided or the status of the
127.24 patient; and

127.25 (6) requirements for the involvement of a patient's physician or advanced practice
127.26 registered nurse; documentation of physicians' or advanced practice registered nurses' orders,
127.27 if required, and the patient's hospice plan of care; and maintenance of accurate, current
127.28 clinical records.

127.29 Sec. 64. Minnesota Statutes 2018, section 145.853, subdivision 5, is amended to read:

127.30 Subd. 5. **Notification; medical care.** A law enforcement officer who determines or has
127.31 reason to believe that a disabled person is suffering from an illness causing the person's

128.1 condition shall promptly notify the person's physician or advanced practice registered nurse,
128.2 if practicable. If the officer is unable to ascertain the physician's or advanced practice
128.3 registered nurse's identity or to communicate with the physician or advanced practice
128.4 registered nurse, the officer shall make a reasonable effort to cause the disabled person to
128.5 be transported immediately to a medical practitioner or to a facility where medical treatment
128.6 is available. If the officer believes it unduly dangerous to move the disabled person, the
128.7 officer shall make a reasonable effort to obtain the assistance of a medical practitioner.

128.8 Sec. 65. Minnesota Statutes 2018, section 145.892, subdivision 3, is amended to read:

128.9 Subd. 3. **Pregnant woman.** "Pregnant woman" means an individual determined by a
128.10 licensed physician, advanced practice registered nurse, midwife, or appropriately trained
128.11 registered nurse to have one or more fetuses in utero.

128.12 Sec. 66. Minnesota Statutes 2018, section 145.94, subdivision 2, is amended to read:

128.13 Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or
128.14 to the community, information including data made nonpublic by law, relating to the
128.15 hazardous properties and health hazards of hazardous substances released from a workplace
128.16 if the commissioner finds:

128.17 (1) evidence that a person requesting the information may have suffered or is likely to
128.18 suffer illness or injury from exposure to a hazardous substance; or

128.19 (2) evidence of a community health risk and if the commissioner seeks to have the
128.20 employer cease an activity which results in release of a hazardous substance.

128.21 Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage
128.22 according to established standards to prevent unauthorized use or disclosure. If the nonpublic
128.23 data is required for the diagnosis, treatment, or prevention of illness or injury, a personal
128.24 physician or advanced practice registered nurse may be provided with this information if
128.25 the physician or advanced practice registered nurse agrees to preserve the confidentiality
128.26 of the information, except for patient health records subject to sections 144.291 to 144.298.
128.27 After the disclosure of any hazardous substance information relating to a particular
128.28 workplace, the commissioner shall advise the employer of the information disclosed, the
128.29 date of the disclosure, and the person who received the information.

129.1 Sec. 67. Minnesota Statutes 2018, section 145B.13, is amended to read:

129.2 **145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.**

129.3 In reliance on a patient's living will, a decision to administer, withhold, or withdraw
129.4 medical treatment after the patient has been diagnosed by the attending physician or advanced
129.5 practice registered nurse to be in a terminal condition must always be based on reasonable
129.6 medical practice, including:

129.7 (1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human
129.8 dignity and to alleviate pain;

129.9 (2) oral administration of food or water to a patient who accepts it, except for clearly
129.10 documented medical reasons; and

129.11 (3) in the case of a living will of a patient that the attending physician or advanced
129.12 practice registered nurse knows is pregnant, the living will must not be given effect as long
129.13 as it is possible that the fetus could develop to the point of live birth with continued
129.14 application of life-sustaining treatment.

129.15 Sec. 68. Minnesota Statutes 2018, section 145C.02, is amended to read:

129.16 **145C.02 HEALTH CARE DIRECTIVE.**

129.17 A principal with the capacity to do so may execute a health care directive. A health care
129.18 directive may include one or more health care instructions to direct health care providers,
129.19 others assisting with health care, family members, and a health care agent. A health care
129.20 directive may include a health care power of attorney to appoint a health care agent to make
129.21 health care decisions for the principal when the principal, in the judgment of the principal's
129.22 attending physician or advanced practice registered nurse, lacks decision-making capacity,
129.23 unless otherwise specified in the health care directive.

129.24 Sec. 69. Minnesota Statutes 2019 Supplement, section 145C.05, subdivision 2, is amended
129.25 to read:

129.26 Subd. 2. **Provisions that may be included.** (a) A health care directive may include
129.27 provisions consistent with this chapter, including, but not limited to:

129.28 (1) the designation of one or more alternate health care agents to act if the named health
129.29 care agent is not reasonably available to serve;

130.1 (2) directions to joint health care agents regarding the process or standards by which the
130.2 health care agents are to reach a health care decision for the principal, and a statement
130.3 whether joint health care agents may act independently of one another;

130.4 (3) limitations, if any, on the right of the health care agent or any alternate health care
130.5 agents to receive, review, obtain copies of, and consent to the disclosure of the principal's
130.6 medical records or to visit the principal when the principal is a patient in a health care
130.7 facility;

130.8 (4) limitations, if any, on the nomination of the health care agent as guardian for purposes
130.9 of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

130.10 (5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter
130.11 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

130.12 (6) a declaration regarding intrusive mental health treatment under section 253B.03,
130.13 subdivision 6d, or a statement that the health care agent is authorized to give consent for
130.14 the principal under section 253B.04, subdivision 1a;

130.15 (7) a funeral directive as provided in section 149A.80, subdivision 2;

130.16 (8) limitations, if any, to the effect of dissolution or annulment of marriage or termination
130.17 of domestic partnership on the appointment of a health care agent under section 145C.09,
130.18 subdivision 2;

130.19 (9) specific reasons why a principal wants a health care provider or an employee of a
130.20 health care provider attending the principal to be eligible to act as the principal's health care
130.21 agent;

130.22 (10) health care instructions by a woman of child bearing age regarding how she would
130.23 like her pregnancy, if any, to affect health care decisions made on her behalf;

130.24 (11) health care instructions regarding artificially administered nutrition or hydration;
130.25 and

130.26 (12) health care instructions to prohibit administering, dispensing, or prescribing an
130.27 opioid, except that these instructions must not be construed to limit the administering,
130.28 dispensing, or prescribing an opioid to treat substance abuse, opioid dependence, or an
130.29 overdose, unless otherwise prohibited in the health care directive.

130.30 (b) A health care directive may include a statement of the circumstances under which
130.31 the directive becomes effective other than upon the judgment of the principal's attending
130.32 physician or advanced practice registered nurse in the following situations:

131.1 (1) a principal who in good faith generally selects and depends upon spiritual means or
131.2 prayer for the treatment or care of disease or remedial care and does not have an attending
131.3 physician or advanced practice registered nurse, may include a statement appointing an
131.4 individual who may determine the principal's decision-making capacity; and

131.5 (2) a principal who in good faith does not generally select a physician or advanced
131.6 practice registered nurse or a health care facility for the principal's health care needs may
131.7 include a statement appointing an individual who may determine the principal's
131.8 decision-making capacity, provided that if the need to determine the principal's capacity
131.9 arises when the principal is receiving care under the direction of an attending physician or
131.10 advanced practice registered nurse in a health care facility, the determination must be made
131.11 by an attending physician or advanced practice registered nurse after consultation with the
131.12 appointed individual.

131.13 If a person appointed under clause (1) or (2) is not reasonably available and the principal
131.14 is receiving care under the direction of an attending physician or advanced practice registered
131.15 nurse in a health care facility, an attending physician or advanced practice registered nurse
131.16 shall determine the principal's decision-making capacity.

131.17 (c) A health care directive may authorize a health care agent to make health care decisions
131.18 for a principal even though the principal retains decision-making capacity.

131.19 Sec. 70. Minnesota Statutes 2018, section 145C.06, is amended to read:

131.20 **145C.06 WHEN EFFECTIVE.**

131.21 A health care directive is effective for a health care decision when:

131.22 (1) it meets the requirements of section 145C.03, subdivision 1; and

131.23 (2) the principal, in the determination of the attending physician or advanced practice
131.24 registered nurse of the principal, lacks decision-making capacity to make the health care
131.25 decision; or if other conditions for effectiveness otherwise specified by the principal have
131.26 been met.

131.27 A health care directive is not effective for a health care decision when the principal, in
131.28 the determination of the attending physician or advanced practice registered nurse of the
131.29 principal, recovers decision-making capacity; or if other conditions for effectiveness
131.30 otherwise specified by the principal have been met.

132.1 Sec. 71. Minnesota Statutes 2018, section 145C.07, subdivision 1, is amended to read:

132.2 Subdivision 1. **Authority.** The health care agent has authority to make any particular
132.3 health care decision only if the principal lacks decision-making capacity, in the determination
132.4 of the attending physician or advanced practice registered nurse, to make or communicate
132.5 that health care decision; or if other conditions for effectiveness otherwise specified by the
132.6 principal have been met. The physician, advanced practice registered nurse, or other health
132.7 care provider shall continue to obtain the principal's informed consent to all health care
132.8 decisions for which the principal has decision-making capacity, unless other conditions for
132.9 effectiveness otherwise specified by the principal have been met. An alternate health care
132.10 agent has authority to act if the primary health care agent is not reasonably available to act.

132.11 Sec. 72. Minnesota Statutes 2018, section 145C.16, is amended to read:

132.12 **145C.16 SUGGESTED FORM.**

132.13 The following is a suggested form of a health care directive and is not a required form.

132.14 HEALTH CARE DIRECTIVE

132.15 I,, understand this document allows me to do ONE OR BOTH of the
132.16 following:

132.17 PART I: Name another person (called the health care agent) to make health care decisions
132.18 for me if I am unable to decide or speak for myself. My health care agent must make health
132.19 care decisions for me based on the instructions I provide in this document (Part II), if any,
132.20 the wishes I have made known to him or her, or must act in my best interest if I have not
132.21 made my health care wishes known.

132.22 AND/OR

132.23 PART II: Give health care instructions to guide others making health care decisions for
132.24 me. If I have named a health care agent, these instructions are to be used by the agent. These
132.25 instructions may also be used by my health care providers, others assisting with my health
132.26 care and my family, in the event I cannot make decisions for myself.

132.27 PART I: APPOINTMENT OF HEALTH CARE AGENT

132.28 THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
132.29 FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

132.30 (I know I can change my agent or alternate agent at any time and I know I do not have
132.31 to appoint an agent or an alternate agent)

133.1 NOTE: If you appoint an agent, you should discuss this health care directive with your agent
 133.2 and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I
 133.3 blank and go to Part II.

133.4 When I am unable to decide or speak for myself, I trust and appoint to
 133.5 make health care decisions for me. This person is called my health care agent.

133.6 Relationship of my health care agent to me:.....

133.7 Telephone number of my health care agent:.....

133.8 Address of my health care agent:.....

133.9 (OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my
 133.10 health care agent is not reasonably available, I trust and appoint to be my health
 133.11 care agent instead.

133.12 Relationship of my alternate health care agent to me:.....

133.13 Telephone number of my alternate health care agent:.....

133.14 Address of my alternate health care agent:.....

133.15 THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO
 133.16 DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF
 133.17 (I know I can change these choices)

133.18 My health care agent is automatically given the powers listed below in (A) through (D).
 133.19 My health care agent must follow my health care instructions in this document or any other
 133.20 instructions I have given to my agent. If I have not given health care instructions, then my
 133.21 agent must act in my best interest.

133.22 Whenever I am unable to decide or speak for myself, my health care agent has the power
 133.23 to:

133.24 (A) Make any health care decision for me. This includes the power to give, refuse, or
 133.25 withdraw consent to any care, treatment, service, or procedures. This includes deciding
 133.26 whether to stop or not start health care that is keeping me or might keep me alive, and
 133.27 deciding about intrusive mental health treatment.

133.28 (B) Choose my health care providers.

133.29 (C) Choose where I live and receive care and support when those choices relate to my
 133.30 health care needs.

134.1 (D) Review my medical records and have the same rights that I would have to give my
134.2 medical records to other people.

134.3 If I DO NOT want my health care agent to have a power listed above in (A) through (D)
134.4 OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

134.5
134.6
134.7

134.8 My health care agent is NOT automatically given the powers listed below in (1) and (2).
134.9 If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in
134.10 front of the power; then my agent WILL HAVE that power.

134.11 (1) To decide whether to donate any parts of my body, including organs, tissues,
134.12 and eyes, when I die.

134.13 (2) To decide what will happen with my body when I die (burial, cremation).

134.14 If I want to say anything more about my health care agent's powers or limits on the
134.15 powers, I can say it here:

134.16
134.17
134.18

134.19 PART II: HEALTH CARE INSTRUCTIONS

134.20 NOTE: Complete this Part II if you wish to give health care instructions. If you appointed
134.21 an agent in Part I, completing this Part II is optional but would be very helpful to your agent.
134.22 However, if you chose not to appoint an agent in Part I, you MUST complete some or all
134.23 of this Part II if you wish to make a valid health care directive.

134.24 These are instructions for my health care when I am unable to decide or speak for myself.
134.25 These instructions must be followed (so long as they address my needs).

134.26 THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

134.27 (I know I can change these choices or leave any of them blank)

134.28 I want you to know these things about me to help you make decisions about my health
134.29 care:

134.30 My goals for my health care:.....
134.31

135.1

135.2 My fears about my health care:.....

135.3

135.4

135.5 My spiritual or religious beliefs and traditions:.....

135.6

135.7

135.8 My beliefs about when life would be no longer worth living:.....

135.9

135.10

135.11 My thoughts about how my medical condition might affect my family:

135.12

135.13

135.14 THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

135.15 (I know I can change these choices or leave any of them blank)

135.16 Many medical treatments may be used to try to improve my medical condition or to
135.17 prolong my life. Examples include artificial breathing by a machine connected to a tube in
135.18 the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries,
135.19 dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a
135.20 while and then stopped if they do not help.

135.21 I have these views about my health care in these situations:

135.22 (Note: You can discuss general feelings, specific treatments, or leave any of them blank)

135.23 If I had a reasonable chance of recovery, and were temporarily unable to decide or speak
135.24 for myself, I would want:.....

135.25

135.26

135.27 If I were dying and unable to decide or speak for myself, I would want:.....

135.28

136.1

136.2 If I were permanently unconscious and unable to decide or speak for myself, I would

136.3 want:.....

136.4

136.5

136.6 If I were completely dependent on others for my care and unable to decide or speak for

136.7 myself, I would want:.....

136.8

136.9

136.10 In all circumstances, my doctors or advanced practice registered nurses will try to keep

136.11 me comfortable and reduce my pain. This is how I feel about pain relief if it would affect

136.12 my alertness or if it could shorten my life:.....

136.13

136.14

136.15 There are other things that I want or do not want for my health care, if possible:

136.16 Who I would like to be my doctor or advanced practice registered nurse:.....

136.17

136.18

136.19 Where I would like to live to receive health care:.....

136.20

136.21

136.22 Where I would like to die and other wishes I have about dying:.....

136.23

136.24

136.25 My wishes about donating parts of my body when I die:.....

136.26

136.27

136.28 My wishes about what happens to my body when I die (cremation, burial):.....

137.1

137.2

137.3 Any other things:.....

137.4

137.5

137.6 PART III: MAKING THE DOCUMENT LEGAL

137.7 This document must be signed by me. It also must either be verified by a notary public
137.8 (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified
137.9 or witnessed.

137.10 I am thinking clearly, I agree with everything that is written in this document, and I have
137.11 made this document willingly.

137.12

137.13 My Signature

137.14 Date signed:

137.15 Date of birth:

137.16 Address:

137.17

137.18 If I cannot sign my name, I can ask someone to sign this document for me.

137.19

137.20 Signature of the person who I asked to sign this document for me.

137.21

137.22 Printed name of the person who I asked to sign this document for me.

137.23 Option 1: Notary Public

137.24 In my presence on (date), (name) acknowledged his/her
137.25 signature on this document or acknowledged that he/she authorized the person signing this
137.26 document to sign on his/her behalf. I am not named as a health care agent or alternate health
137.27 care agent in this document.

137.28

137.29 (Signature of Notary)

(Notary Stamp)

137.30 Option 2: Two Witnesses

138.1 Two witnesses must sign. Only one of the two witnesses can be a health care provider
 138.2 or an employee of a health care provider giving direct care to me on the day I sign this
 138.3 document.

138.4 Witness One:

138.5 (i) In my presence on (date), (name) acknowledged his/her signature
 138.6 on this document or acknowledged that he/she authorized the person signing this document
 138.7 to sign on his/her behalf.

138.8 (ii) I am at least 18 years of age.

138.9 (iii) I am not named as a health care agent or an alternate health care agent in this
 138.10 document.

138.11 (iv) If I am a health care provider or an employee of a health care provider giving direct
 138.12 care to the person listed above in (A), I must initial this box: []

138.13 I certify that the information in (i) through (iv) is true and correct.

138.14

138.15 (Signature of Witness One)

138.16 Address:

138.17

138.18 Witness Two:

138.19 (i) In my presence on (date), (name) acknowledged his/her signature
 138.20 on this document or acknowledged that he/she authorized the person signing this document
 138.21 to sign on his/her behalf.

138.22 (ii) I am at least 18 years of age.

138.23 (iii) I am not named as a health care agent or an alternate health care agent in this
 138.24 document.

138.25 (iv) If I am a health care provider or an employee of a health care provider giving direct
 138.26 care to the person listed above in (A), I must initial this box: []

138.27 I certify that the information in (i) through (iv) is true and correct.

138.28

138.29 (Signature of Witness Two)

138.30 Address:

138.31

139.1 REMINDER: Keep this document with your personal papers in a safe place (not in a safe
139.2 deposit box). Give signed copies to your doctors or advanced practice registered nurses,
139.3 family, close friends, health care agent, and alternate health care agent. Make sure your
139.4 doctor or advanced practice registered nurse is willing to follow your wishes. This document
139.5 should be part of your medical record at your physician's or advanced practice registered
139.6 nurse's office and at the hospital, home care agency, hospice, or nursing facility where you
139.7 receive your care.

139.8 Sec. 73. Minnesota Statutes 2018, section 148.6438, subdivision 1, is amended to read:

139.9 Subdivision 1. **Required notification.** In the absence of a physician or advanced practice
139.10 registered nurse referral or prior authorization, and before providing occupational therapy
139.11 services for remuneration or expectation of payment from the client, an occupational therapist
139.12 must provide the following written notification in all capital letters of 12-point or larger
139.13 boldface type, to the client, parent, or guardian:

139.14 "Your health care provider, insurer, or plan may require a physician or advanced practice
139.15 registered nurse referral or prior authorization and you may be obligated for partial or full
139.16 payment for occupational therapy services rendered."

139.17 Information other than this notification may be included as long as the notification
139.18 remains conspicuous on the face of the document. A nonwritten disclosure format may be
139.19 used to satisfy the recipient notification requirement when necessary to accommodate the
139.20 physical condition of a client or client's guardian.

139.21 Sec. 74. Minnesota Statutes 2018, section 151.19, subdivision 4, is amended to read:

139.22 Subd. 4. **Licensing of physicians and advanced practice registered nurses to dispense**
139.23 **drugs; renewals.** (a) The board may grant a license to any physician licensed under chapter
139.24 147 or advanced practice registered nurse licensed under chapter 148 who provides services
139.25 in a health care facility located in a designated health professional shortage area authorizing
139.26 the physician or advanced practice registered nurse to dispense drugs to individuals for
139.27 whom pharmaceutical care is not reasonably available. The license may be renewed annually.
139.28 Any physician or advanced practice registered nurse licensed under this subdivision shall
139.29 be limited to dispensing drugs in a limited service pharmacy and shall be governed by the
139.30 rules adopted by the board when dispensing drugs.

139.31 (b) For the purposes of this subdivision, pharmaceutical care is not reasonably available
139.32 if the limited service pharmacy in which the physician or advanced practice registered nurse

140.1 is dispensing drugs is located in a health professional shortage area, and no other licensed
140.2 pharmacy is located within 15 miles of the limited service pharmacy.

140.3 (c) For the purposes of this subdivision, section 151.15, subdivision 2, shall not apply,
140.4 and section 151.215 shall not apply provided that a physician or advanced practice registered
140.5 nurse granted a license under this subdivision certifies each filled prescription in accordance
140.6 with Minnesota Rules, part 6800.3100, subpart 3.

140.7 (d) Notwithstanding section 151.102, a physician or advanced practice registered nurse
140.8 granted a license under this subdivision may be assisted by a pharmacy technician if the
140.9 technician holds a valid certification from the Pharmacy Technician Certification Board or
140.10 from another national certification body for pharmacy technicians that requires passage of
140.11 a nationally recognized psychometrically valid certification examination for certification
140.12 as determined by the board. The physician or advanced practice registered nurse may
140.13 supervise the pharmacy technician as long as the physician or advanced practice registered
140.14 nurse assumes responsibility for all functions performed by the technician. For purposes of
140.15 this subdivision, supervision does not require the physician or advanced practice registered
140.16 nurse to be physically present if the physician, advanced practice registered nurse, or a
140.17 licensed pharmacist is available, either electronically or by telephone.

140.18 (e) Nothing in this subdivision shall be construed to prohibit a physician or advanced
140.19 practice registered nurse from dispensing drugs pursuant to section 151.37 and Minnesota
140.20 Rules, parts 6800.9950 to 6800.9954.

140.21 Sec. 75. Minnesota Statutes 2018, section 151.21, subdivision 4a, is amended to read:

140.22 Subd. 4a. **Sign.** A pharmacy must post a sign in a conspicuous location and in a typeface
140.23 easily seen at the counter where prescriptions are dispensed stating: "In order to save you
140.24 money, this pharmacy will substitute whenever possible an FDA-approved, less expensive,
140.25 generic drug product, which is therapeutically equivalent to and safely interchangeable with
140.26 the one prescribed by your doctor or advanced practice registered nurse, unless you object
140.27 to this substitution."

140.28 Sec. 76. Minnesota Statutes 2018, section 152.32, subdivision 3, is amended to read:

140.29 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
140.30 lease to and may not otherwise penalize a person solely for the person's status as a patient
140.31 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
140.32 would violate federal law or regulations or cause the school or landlord to lose a monetary
140.33 or licensing-related benefit under federal law or regulations.

141.1 (b) For the purposes of medical care, including organ transplants, a registry program
141.2 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
141.3 equivalent of the authorized use of any other medication used at the discretion of a physician
141.4 or advanced practice registered nurse and does not constitute the use of an illicit substance
141.5 or otherwise disqualify a patient from needed medical care.

141.6 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
141.7 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
141.8 may not discriminate against a person in hiring, termination, or any term or condition of
141.9 employment, or otherwise penalize a person, if the discrimination is based upon either of
141.10 the following:

141.11 (1) the person's status as a patient enrolled in the registry program under sections 152.22
141.12 to 152.37; or

141.13 (2) a patient's positive drug test for cannabis components or metabolites, unless the
141.14 patient used, possessed, or was impaired by medical cannabis on the premises of the place
141.15 of employment or during the hours of employment.

141.16 (d) An employee who is required to undergo employer drug testing pursuant to section
141.17 181.953 may present verification of enrollment in the patient registry as part of the employee's
141.18 explanation under section 181.953, subdivision 6.

141.19 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
141.20 time with a minor child solely based on the person's status as a patient enrolled in the registry
141.21 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
141.22 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
141.23 behavior is such that it creates an unreasonable danger to the safety of the minor as
141.24 established by clear and convincing evidence.

141.25 Sec. 77. Minnesota Statutes 2018, section 245A.143, subdivision 8, is amended to read:

141.26 Subd. 8. **Nutritional services.** (a) The license holder shall ensure that food served is
141.27 nutritious and meets any special dietary needs of the participants as prescribed by the
141.28 participant's physician, advanced practice registered nurse, or dietitian as specified in the
141.29 service delivery plan.

141.30 (b) Food and beverages must be obtained, handled, and properly stored to prevent
141.31 contamination, spoilage, or a threat to the health of a resident.

142.1 Sec. 78. Minnesota Statutes 2018, section 245A.1435, is amended to read:

142.2 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH**
142.3 **IN LICENSED PROGRAMS.**

142.4 (a) When a license holder is placing an infant to sleep, the license holder must place the
142.5 infant on the infant's back, unless the license holder has documentation from the infant's
142.6 physician or advanced practice registered nurse directing an alternative sleeping position
142.7 for the infant. The physician or advanced practice registered nurse directive must be on a
142.8 form approved by the commissioner and must remain on file at the licensed location. An
142.9 infant who independently rolls onto its stomach after being placed to sleep on its back may
142.10 be allowed to remain sleeping on its stomach if the infant is at least six months of age or
142.11 the license holder has a signed statement from the parent indicating that the infant regularly
142.12 rolls over at home.

142.13 (b) The license holder must place the infant in a crib directly on a firm mattress with a
142.14 fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and
142.15 overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of
142.16 the sheet with reasonable effort. The license holder must not place anything in the crib with
142.17 the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title
142.18 16, part 1511. The requirements of this section apply to license holders serving infants
142.19 younger than one year of age. Licensed child care providers must meet the crib requirements
142.20 under section 245A.146. A correction order shall not be issued under this paragraph unless
142.21 there is evidence that a violation occurred when an infant was present in the license holder's
142.22 care.

142.23 (c) If an infant falls asleep before being placed in a crib, the license holder must move
142.24 the infant to a crib as soon as practicable, and must keep the infant within sight of the license
142.25 holder until the infant is placed in a crib. When an infant falls asleep while being held, the
142.26 license holder must consider the supervision needs of other children in care when determining
142.27 how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant
142.28 must not be in a position where the airway may be blocked or with anything covering the
142.29 infant's face.

142.30 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
142.31 for an infant of any age and is prohibited for any infant who has begun to roll over
142.32 independently. However, with the written consent of a parent or guardian according to this
142.33 paragraph, a license holder may place the infant who has not yet begun to roll over on its
142.34 own down to sleep in a one-piece sleeper equipped with an attached system that fastens

143.1 securely only across the upper torso, with no constriction of the hips or legs, to create a
143.2 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
143.3 the license holder must obtain informed written consent for the use of swaddling from the
143.4 parent or guardian of the infant on a form provided by the commissioner and prepared in
143.5 partnership with the Minnesota Sudden Infant Death Center.

143.6 Sec. 79. Minnesota Statutes 2018, section 245C.02, subdivision 18, is amended to read:

143.7 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
143.8 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
143.9 the care of a physician or advanced practice registered nurse whether or not the care of a
143.10 physician or advanced practice registered nurse was sought, or abuse resulting in serious
143.11 injury.

143.12 (b) For purposes of this definition, "care of a physician or advanced practice registered
143.13 nurse" is treatment received or ordered by a physician, physician assistant, advanced practice
143.14 registered nurse, or nurse practitioner, but does not include:

143.15 (1) diagnostic testing, assessment, or observation;

143.16 (2) the application of, recommendation to use, or prescription solely for a remedy that
143.17 is available over the counter without a prescription; or

143.18 (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up
143.19 appointment.

143.20 (c) For purposes of this definition, "abuse resulting in serious injury" means: bruises,
143.21 bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries;
143.22 head injuries with loss of consciousness; extensive second-degree or third-degree burns and
143.23 other burns for which complications are present; extensive second-degree or third-degree
143.24 frostbite and other frostbite for which complications are present; irreversible mobility or
143.25 avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are
143.26 harmful; near drowning; and heat exhaustion or sunstroke.

143.27 (d) Serious maltreatment includes neglect when it results in criminal sexual conduct
143.28 against a child or vulnerable adult.

143.29 Sec. 80. Minnesota Statutes 2018, section 245C.04, subdivision 1, is amended to read:

143.30 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
143.31 shall conduct a background study of an individual required to be studied under section
143.32 245C.03, subdivision 1, at least upon application for initial license for all license types.

144.1 (b) The commissioner shall conduct a background study of an individual required to be
144.2 studied under section 245C.03, subdivision 1, including a child care background study
144.3 subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed
144.4 child care center, certified license-exempt child care center, or legal nonlicensed child care
144.5 provider, on a schedule determined by the commissioner. Except as provided in section
144.6 245C.05, subdivision 5a, a child care background study must include submission of
144.7 fingerprints for a national criminal history record check and a review of the information
144.8 under section 245C.08. A background study for a child care program must be repeated
144.9 within five years from the most recent study conducted under this paragraph.

144.10 (c) At reapplication for a family child care license:

144.11 (1) for a background study affiliated with a licensed family child care center or legal
144.12 nonlicensed child care provider, the individual shall provide information required under
144.13 section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be
144.14 fingerprinted and photographed under section 245C.05, subdivision 5;

144.15 (2) the county agency shall verify the information received under clause (1) and forward
144.16 the information to the commissioner to complete the background study; and

144.17 (3) the background study conducted by the commissioner under this paragraph must
144.18 include a review of the information required under section 245C.08.

144.19 (d) The commissioner is not required to conduct a study of an individual at the time of
144.20 reapplication for a license if the individual's background study was completed by the
144.21 commissioner of human services and the following conditions are met:

144.22 (1) a study of the individual was conducted either at the time of initial licensure or when
144.23 the individual became affiliated with the license holder;

144.24 (2) the individual has been continuously affiliated with the license holder since the last
144.25 study was conducted; and

144.26 (3) the last study of the individual was conducted on or after October 1, 1995.

144.27 (e) The commissioner of human services shall conduct a background study of an
144.28 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),
144.29 who is newly affiliated with a child foster care license holder:

144.30 (1) the county or private agency shall collect and forward to the commissioner the
144.31 information required under section 245C.05, subdivisions 1 and 5, when the child foster
144.32 care applicant or license holder resides in the home where child foster care services are
144.33 provided;

145.1 (2) the child foster care license holder or applicant shall collect and forward to the
145.2 commissioner the information required under section 245C.05, subdivisions 1 and 5, when
145.3 the applicant or license holder does not reside in the home where child foster care services
145.4 are provided; and

145.5 (3) the background study conducted by the commissioner of human services under this
145.6 paragraph must include a review of the information required under section 245C.08,
145.7 subdivisions 1, 3, and 4.

145.8 (f) The commissioner shall conduct a background study of an individual specified under
145.9 section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated
145.10 with an adult foster care or family adult day services and with a family child care license
145.11 holder or a legal nonlicensed child care provider authorized under chapter 119B and:

145.12 (1) except as provided in section 245C.05, subdivision 5a, the county shall collect and
145.13 forward to the commissioner the information required under section 245C.05, subdivision
145.14 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a), (b), and (d), for background
145.15 studies conducted by the commissioner for all family adult day services, for adult foster
145.16 care when the adult foster care license holder resides in the adult foster care residence, and
145.17 for family child care and legal nonlicensed child care authorized under chapter 119B;

145.18 (2) the license holder shall collect and forward to the commissioner the information
145.19 required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs
145.20 (a) and (b), for background studies conducted by the commissioner for adult foster care
145.21 when the license holder does not reside in the adult foster care residence; and

145.22 (3) the background study conducted by the commissioner under this paragraph must
145.23 include a review of the information required under section 245C.08, subdivision 1, paragraph
145.24 (a), and subdivisions 3 and 4.

145.25 (g) Applicants for licensure, license holders, and other entities as provided in this chapter
145.26 must submit completed background study requests to the commissioner using the electronic
145.27 system known as NETStudy before individuals specified in section 245C.03, subdivision
145.28 1, begin positions allowing direct contact in any licensed program.

145.29 (h) For an individual who is not on the entity's active roster, the entity must initiate a
145.30 new background study through NETStudy when:

145.31 (1) an individual returns to a position requiring a background study following an absence
145.32 of 120 or more consecutive days; or

146.1 (2) a program that discontinued providing licensed direct contact services for 120 or
146.2 more consecutive days begins to provide direct contact licensed services again.

146.3 The license holder shall maintain a copy of the notification provided to the commissioner
146.4 under this paragraph in the program's files. If the individual's disqualification was previously
146.5 set aside for the license holder's program and the new background study results in no new
146.6 information that indicates the individual may pose a risk of harm to persons receiving
146.7 services from the license holder, the previous set-aside shall remain in effect.

146.8 (i) For purposes of this section, a physician licensed under chapter 147 or advanced
146.9 practice registered nurse licensed under chapter 148 is considered to be continuously affiliated
146.10 upon the license holder's receipt from the commissioner of health or human services of the
146.11 physician's or advanced practice registered nurse's background study results.

146.12 (j) For purposes of family child care, a substitute caregiver must receive repeat
146.13 background studies at the time of each license renewal.

146.14 (k) A repeat background study at the time of license renewal is not required if the family
146.15 child care substitute caregiver's background study was completed by the commissioner on
146.16 or after October 1, 2017, and the substitute caregiver is on the license holder's active roster
146.17 in NETStudy 2.0.

146.18 (l) Before and after school programs authorized under chapter 119B, are exempt from
146.19 the background study requirements under section 123B.03, for an employee for whom a
146.20 background study under this chapter has been completed.

146.21 Sec. 81. Minnesota Statutes 2018, section 245D.02, subdivision 11, is amended to read:

146.22 Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires
146.23 the program to make a response that is not a part of the program's ordinary provision of
146.24 services to that person, and includes:

146.25 (1) serious injury of a person as determined by section 245.91, subdivision 6;

146.26 (2) a person's death;

146.27 (3) any medical emergency, unexpected serious illness, or significant unexpected change
146.28 in an illness or medical condition of a person that requires the program to call 911, physician
146.29 or advanced practice registered nurse treatment, or hospitalization;

146.30 (4) any mental health crisis that requires the program to call 911, a mental health crisis
146.31 intervention team, or a similar mental health response team or service when available and
146.32 appropriate;

147.1 (5) an act or situation involving a person that requires the program to call 911, law
147.2 enforcement, or the fire department;

147.3 (6) a person's unauthorized or unexplained absence from a program;

147.4 (7) conduct by a person receiving services against another person receiving services
147.5 that:

147.6 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with a
147.7 person's opportunities to participate in or receive service or support;

147.8 (ii) places the person in actual and reasonable fear of harm;

147.9 (iii) places the person in actual and reasonable fear of damage to property of the person;

147.10 or

147.11 (iv) substantially disrupts the orderly operation of the program;

147.12 (8) any sexual activity between persons receiving services involving force or coercion
147.13 as defined under section 609.341, subdivisions 3 and 14;

147.14 (9) any emergency use of manual restraint as identified in section 245D.061 or successor
147.15 provisions; or

147.16 (10) a report of alleged or suspected child or vulnerable adult maltreatment under section
147.17 626.556 or 626.557.

147.18 Sec. 82. Minnesota Statutes 2018, section 245D.11, subdivision 2, is amended to read:

147.19 Subd. 2. **Health and welfare.** The license holder must establish policies and procedures
147.20 that promote health and welfare by ensuring:

147.21 (1) use of universal precautions and sanitary practices in compliance with section
147.22 245D.06, subdivision 2, clause (5);

147.23 (2) if the license holder operates a residential program, health service coordination and
147.24 care according to the requirements in section 245D.05, subdivision 1;

147.25 (3) safe medication assistance and administration according to the requirements in
147.26 sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
147.27 consultation with a registered nurse, ~~nurse practitioner~~ advanced practice registered nurse,
147.28 physician assistant, or medical doctor and require completion of medication administration
147.29 training according to the requirements in section 245D.09, subdivision 4a, paragraph (d).

147.30 Medication assistance and administration includes, but is not limited to:

147.31 (i) providing medication-related services for a person;

- 148.1 (ii) medication setup;
- 148.2 (iii) medication administration;
- 148.3 (iv) medication storage and security;
- 148.4 (v) medication documentation and charting;
- 148.5 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
- 148.6 handling and administration;
- 148.7 (vii) coordination of medication refills;
- 148.8 (viii) handling changes to prescriptions and implementation of those changes;
- 148.9 (ix) communicating with the pharmacy; and
- 148.10 (x) coordination and communication with prescriber;
- 148.11 (4) safe transportation, when the license holder is responsible for transportation of
- 148.12 persons, with provisions for handling emergency situations according to the requirements
- 148.13 in section 245D.06, subdivision 2, clauses (2) to (4);
- 148.14 (5) a plan for ensuring the safety of persons served by the program in emergencies as
- 148.15 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
- 148.16 to the license holder. A license holder with a community residential setting or a day service
- 148.17 facility license must ensure the policy and procedures comply with the requirements in
- 148.18 section 245D.22, subdivision 4;
- 148.19 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11;
- 148.20 and reporting all incidents required to be reported according to section 245D.06, subdivision
- 148.21 1. The plan must:
- 148.22 (i) provide the contact information of a source of emergency medical care and
- 148.23 transportation; and
- 148.24 (ii) require staff to first call 911 when the staff believes a medical emergency may be
- 148.25 life threatening, or to call the mental health crisis intervention team or similar mental health
- 148.26 response team or service when such a team is available and appropriate when the person is
- 148.27 experiencing a mental health crisis; and
- 148.28 (7) a procedure for the review of incidents and emergencies to identify trends or patterns,
- 148.29 and corrective action if needed. The license holder must establish and maintain a
- 148.30 record-keeping system for the incident and emergency reports. Each incident and emergency
- 148.31 report file must contain a written summary of the incident. The license holder must conduct

149.1 a review of incident reports for identification of incident patterns, and implementation of
149.2 corrective action as necessary to reduce occurrences. Each incident report must include:

149.3 (i) the name of the person or persons involved in the incident. It is not necessary to
149.4 identify all persons affected by or involved in an emergency unless the emergency resulted
149.5 in an incident;

149.6 (ii) the date, time, and location of the incident or emergency;

149.7 (iii) a description of the incident or emergency;

149.8 (iv) a description of the response to the incident or emergency and whether a person's
149.9 coordinated service and support plan addendum or program policies and procedures were
149.10 implemented as applicable;

149.11 (v) the name of the staff person or persons who responded to the incident or emergency;
149.12 and

149.13 (vi) the determination of whether corrective action is necessary based on the results of
149.14 the review.

149.15 Sec. 83. Minnesota Statutes 2018, section 245D.22, subdivision 7, is amended to read:

149.16 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin-operated
149.17 telephone that is readily accessible. A list of emergency numbers must be posted in a
149.18 prominent location. When an area has a 911 number or a mental health crisis intervention
149.19 team number, both numbers must be posted and the emergency number listed must be 911.
149.20 In areas of the state without a 911 number, the numbers listed must be those of the local
149.21 fire department, police department, emergency transportation, and poison control center.
149.22 The names and telephone numbers of each person's representative, physician or advanced
149.23 practice registered nurse, and dentist must be readily available.

149.24 Sec. 84. Minnesota Statutes 2018, section 245D.25, subdivision 2, is amended to read:

149.25 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed
149.26 by the person's physician, advanced practice registered nurse, or dietitian. Three nutritionally
149.27 balanced meals a day must be served or made available to persons, and nutritious snacks
149.28 must be available between meals.

149.29 Sec. 85. Minnesota Statutes 2018, section 245G.08, subdivision 2, is amended to read:

149.30 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
149.31 obtaining a medical intervention for a client, that are approved in writing by a physician

150.1 who is licensed under chapter 147 or advanced practice registered nurse who is licensed
150.2 under chapter 148, unless:

150.3 (1) the license holder does not provide a service under section 245G.21; and

150.4 (2) a medical intervention is referred to 911, the emergency telephone number, or the
150.5 client's physician or advanced practice registered nurse.

150.6 Sec. 86. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended
150.7 to read:

150.8 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone
150.9 available for emergency treatment of opioid overdose must have a written standing order
150.10 protocol by a physician who is licensed under chapter 147 or advanced practice registered
150.11 nurse who is licensed under chapter 148, that permits the license holder to maintain a supply
150.12 of naloxone on site. A license holder must require staff to undergo training in the specific
150.13 mode of administration used at the program, which may include intranasal administration,
150.14 intramuscular injection, or both.

150.15 Sec. 87. Minnesota Statutes 2018, section 245G.08, subdivision 5, is amended to read:

150.16 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
150.17 license holder must meet the requirements in this subdivision if a service provided includes
150.18 the administration of medication.

150.19 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
150.20 licensed practitioner or a registered nurse the task of administration of medication or assisting
150.21 with self-medication, must:

150.22 (1) successfully complete a medication administration training program for unlicensed
150.23 personnel through an accredited Minnesota postsecondary educational institution. A staff
150.24 member's completion of the course must be documented in writing and placed in the staff
150.25 member's personnel file;

150.26 (2) be trained according to a formalized training program that is taught by a registered
150.27 nurse and offered by the license holder. The training must include the process for
150.28 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
150.29 training must be documented in writing and placed in the staff member's personnel records;
150.30 or

151.1 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
 151.2 registered nurse must be employed or contracted to develop the policies and procedures for
 151.3 administration of medication or assisting with self-administration of medication, or both.

151.4 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
 151.5 23. The registered nurse's supervision must include, at a minimum, monthly on-site
 151.6 supervision or more often if warranted by a client's health needs. The policies and procedures
 151.7 must include:

151.8 (1) a provision that a delegation of administration of medication is limited to the
 151.9 administration of a medication that is administered orally, topically, or as a suppository, an
 151.10 eye drop, an ear drop, or an inhalant;

151.11 (2) a provision that each client's file must include documentation indicating whether
 151.12 staff must conduct the administration of medication or the client must self-administer
 151.13 medication, or both;

151.14 (3) a provision that a client may carry emergency medication such as nitroglycerin as
 151.15 instructed by the client's physician or advanced practice registered nurse;

151.16 (4) a provision for the client to self-administer medication when a client is scheduled to
 151.17 be away from the facility;

151.18 (5) a provision that if a client self-administers medication when the client is present in
 151.19 the facility, the client must self-administer medication under the observation of a trained
 151.20 staff member;

151.21 (6) a provision that when a license holder serves a client who is a parent with a child,
 151.22 the parent may only administer medication to the child under a staff member's supervision;

151.23 (7) requirements for recording the client's use of medication, including staff signatures
 151.24 with date and time;

151.25 (8) guidelines for when to inform a nurse of problems with self-administration of
 151.26 medication, including a client's failure to administer, refusal of a medication, adverse
 151.27 reaction, or error; and

151.28 (9) procedures for acceptance, documentation, and implementation of a prescription,
 151.29 whether written, verbal, telephonic, or electronic.

151.30 Sec. 88. Minnesota Statutes 2018, section 245G.21, subdivision 2, is amended to read:

151.31 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
 151.32 the license holder. The license holder must set and post a notice of visiting rules and hours,

152.1 including both day and evening times. A client's right to receive visitors other than a personal
152.2 physician or advanced practice registered nurse, religious adviser, county case manager,
152.3 parole or probation officer, or attorney may be subject to visiting hours established by the
152.4 license holder for all clients. The treatment director or designee may impose limitations as
152.5 necessary for the welfare of a client provided the limitation and the reasons for the limitation
152.6 are documented in the client's file. A client must be allowed to receive visits at all reasonable
152.7 times from the client's personal physician or advanced practice registered nurse, religious
152.8 adviser, county case manager, parole or probation officer, and attorney.

152.9 Sec. 89. Minnesota Statutes 2018, section 245G.21, subdivision 3, is amended to read:

152.10 Subd. 3. **Client property management.** A license holder who provides room and board
152.11 and treatment services to a client in the same facility, and any license holder that accepts
152.12 client property must meet the requirements for handling client funds and property in section
152.13 245A.04, subdivision 13. License holders:

152.14 (1) may establish policies regarding the use of personal property to ensure that treatment
152.15 activities and the rights of other clients are not infringed upon;

152.16 (2) may take temporary custody of a client's property for violation of a facility policy;

152.17 (3) must retain the client's property for a minimum of seven days after the client's service
152.18 termination if the client does not reclaim property upon service termination, or for a minimum
152.19 of 30 days if the client does not reclaim property upon service termination and has received
152.20 room and board services from the license holder; and

152.21 (4) must return all property held in trust to the client at service termination regardless
152.22 of the client's service termination status, except that:

152.23 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
152.24 609.5316, must be given to the custody of a local law enforcement agency. If giving the
152.25 property to the custody of a local law enforcement agency violates Code of Federal
152.26 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
152.27 paraphernalia, or drug container must be destroyed by a staff member designated by the
152.28 program director; and

152.29 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
152.30 others must be given to the custody of a local law enforcement agency, and the client must
152.31 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
152.32 and

153.1 (iii) a medication that was determined by a physician or advanced practice registered
153.2 nurse to be harmful after examining the client must be destroyed, except when the client's
153.3 personal physician or advanced practice registered nurse approves the medication for
153.4 continued use.

153.5 Sec. 90. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

153.6 **245H.11 REPORTING.**

153.7 (a) The certification holder must comply and must have written policies for staff to
153.8 comply with the reporting requirements for abuse and neglect specified in section 626.556.
153.9 A person mandated to report physical or sexual child abuse or neglect occurring within a
153.10 certified center shall report the information to the commissioner.

153.11 (b) The certification holder must inform the commissioner within 24 hours of:

153.12 (1) the death of a child in the program; and

153.13 (2) any injury to a child in the program that required treatment by a physician or advanced
153.14 practice registered nurse.

153.15 Sec. 91. Minnesota Statutes 2018, section 246.711, subdivision 2, is amended to read:

153.16 Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections
153.17 246.71 to 246.722 when all of the following conditions are met:

153.18 (1) a licensed physician or advanced practice registered nurse determines that a significant
153.19 exposure has occurred following the protocol under section 246.721;

153.20 (2) the licensed physician or advanced practice registered nurse for the employee needs
153.21 the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue
153.22 treatment in accordance with the most current guidelines of the United States Public Health
153.23 Service, because of possible exposure to a blood-borne pathogen; and

153.24 (3) the employee consents to providing a blood sample for testing for a blood-borne
153.25 pathogen.

153.26 Sec. 92. Minnesota Statutes 2018, section 246.715, subdivision 2, is amended to read:

153.27 Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but
153.28 does not consent to blood-borne pathogens testing, the secure treatment facility shall ensure
153.29 that the blood is tested for blood-borne pathogens if the employee requests the test, provided
153.30 all of the following criteria are met:

154.1 (1) the employee and secure treatment facility have documented exposure to blood or
154.2 body fluids during performance of the employee's work duties;

154.3 (2) a licensed physician or advanced practice registered nurse has determined that a
154.4 significant exposure has occurred under section 246.711 and has documented that blood-borne
154.5 pathogen test results are needed for beginning, modifying, continuing, or discontinuing
154.6 medical treatment for the employee as recommended by the most current guidelines of the
154.7 United States Public Health Service;

154.8 (3) the employee provides a blood sample for testing for blood-borne pathogens as soon
154.9 as feasible;

154.10 (4) the secure treatment facility asks the patient to consent to a test for blood-borne
154.11 pathogens and the patient does not consent;

154.12 (5) the secure treatment facility has provided the patient and the employee with all of
154.13 the information required by section 246.712; and

154.14 (6) the secure treatment facility has informed the employee of the confidentiality
154.15 requirements of section 246.719 and the penalties for unauthorized release of patient
154.16 information under section 246.72.

154.17 Sec. 93. Minnesota Statutes 2018, section 246.716, subdivision 2, is amended to read:

154.18 Subd. 2. **Procedures without consent.** (a) A secure treatment facility or an employee
154.19 of a secure treatment facility may bring a petition for a court order to require a patient to
154.20 provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in
154.21 the district court in the county where the patient is receiving treatment from the secure
154.22 treatment facility. The secure treatment facility shall serve the petition on the patient three
154.23 days before a hearing on the petition. The petition shall include one or more affidavits
154.24 attesting that:

154.25 (1) the secure treatment facility followed the procedures in sections 246.71 to 246.722
154.26 and attempted to obtain blood-borne pathogen test results according to those sections;

154.27 (2) a licensed physician or advanced practice registered nurse knowledgeable about the
154.28 most current recommendations of the United States Public Health Service has determined
154.29 that a significant exposure has occurred to the employee of a secure treatment facility under
154.30 section 246.721; and

154.31 (3) a physician or advanced practice registered nurse has documented that the employee
154.32 has provided a blood sample and consented to testing for blood-borne pathogens and

155.1 blood-borne pathogen test results are needed for beginning, continuing, modifying, or
155.2 discontinuing medical treatment for the employee under section 246.721.

155.3 (b) Facilities shall cooperate with petitioners in providing any necessary affidavits to
155.4 the extent that facility staff can attest under oath to the facts in the affidavits.

155.5 (c) The court may order the patient to provide a blood sample for blood-borne pathogen
155.6 testing if:

155.7 (1) there is probable cause to believe the employee of a secure treatment facility has
155.8 experienced a significant exposure to the patient;

155.9 (2) the court imposes appropriate safeguards against unauthorized disclosure that must
155.10 specify the persons who have access to the test results and the purposes for which the test
155.11 results may be used;

155.12 (3) a licensed physician or advanced practice registered nurse for the employee of a
155.13 secure treatment facility needs the test results for beginning, continuing, modifying, or
155.14 discontinuing medical treatment for the employee; and

155.15 (4) the court finds a compelling need for the test results. In assessing compelling need,
155.16 the court shall weigh the need for the court-ordered blood collection and test results against
155.17 the interests of the patient, including, but not limited to, privacy, health, safety, or economic
155.18 interests. The court shall also consider whether involuntary blood collection and testing
155.19 would serve the public interests.

155.20 (d) The court shall conduct the proceeding in camera unless the petitioner or the patient
155.21 requests a hearing in open court and the court determines that a public hearing is necessary
155.22 to the public interest and the proper administration of justice.

155.23 (e) The patient may arrange for counsel in any proceeding brought under this subdivision.

155.24 Sec. 94. Minnesota Statutes 2018, section 246.721, is amended to read:

155.25 **246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.**

155.26 (a) A secure treatment facility shall follow applicable Occupational Safety and Health
155.27 Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for
155.28 blood-borne pathogens.

155.29 (b) Every secure treatment facility shall adopt and follow a postexposure protocol for
155.30 employees at a secure treatment facility who have experienced a significant exposure. The
155.31 postexposure protocol must adhere to the most current recommendations of the United
155.32 States Public Health Service and include, at a minimum, the following:

- 156.1 (1) a process for employees to report an exposure in a timely fashion;
- 156.2 (2) a process for an infectious disease specialist, or a licensed physician or advanced
- 156.3 practice registered nurse who is knowledgeable about the most current recommendations
- 156.4 of the United States Public Health Service in consultation with an infectious disease specialist,
- 156.5 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
- 156.6 occurred, and (ii) to provide, under the direction of a licensed physician or advanced practice
- 156.7 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
- 156.8 to the particular blood-borne pathogen or pathogens for which a significant exposure has
- 156.9 been determined;
- 156.10 (3) if there has been a significant exposure, a process to determine whether the patient
- 156.11 has a blood-borne pathogen through disclosure of test results, or through blood collection
- 156.12 and testing as required by sections 246.71 to 246.722;
- 156.13 (4) a process for providing appropriate counseling prior to and following testing for a
- 156.14 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
- 156.15 follow-up recommendations according to the most current recommendations of the United
- 156.16 States Public Health Service, recommendations for testing, and treatment;
- 156.17 (5) a process for providing appropriate counseling under clause (4) to the employee of
- 156.18 a secure treatment facility and to the patient; and
- 156.19 (6) compliance with applicable state and federal laws relating to data practices,
- 156.20 confidentiality, informed consent, and the patient bill of rights.

156.21 Sec. 95. Minnesota Statutes 2018, section 246.722, is amended to read:

156.22 **246.722 IMMUNITY.**

156.23 A secure treatment facility, licensed physician or advanced practice registered nurse,

156.24 and designated health care personnel are immune from liability in any civil, administrative,

156.25 or criminal action relating to the disclosure of test results of a patient to an employee of a

156.26 secure treatment facility and the testing of a blood sample from the patient for blood-borne

156.27 pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

156.28 Sec. 96. Minnesota Statutes 2018, section 251.043, subdivision 1, is amended to read:

156.29 Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in the preceding

156.30 section, the workers' compensation division finds that an employee is suffering from

156.31 tuberculosis contracted in the institution or department by contact with inmates or patients

156.32 therein or by contact with tuberculosis contaminated material therein, it shall order the

157.1 employee to seek the services of a physician, advanced practice registered nurse, or medical
157.2 care facility. There shall be paid to the physician, advanced practice registered nurse, or
157.3 facility where the employee may be received, the same fee for the maintenance and care of
157.4 the person as is received by the institution for the maintenance and care of a nonresident
157.5 patient. If the employee worked in a state hospital or nursing home, payment for the care
157.6 shall be made by the commissioner of human services. If employed in any other institution
157.7 or department the payment shall be made from funds allocated or appropriated for the
157.8 operation of the institution or department. If the employee dies from the effects of the disease
157.9 of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of
157.10 death, the workers' compensation division shall order payment to dependents as provided
157.11 for under the general provisions of the workers' compensation law.

157.12 Sec. 97. Minnesota Statutes 2018, section 252A.02, subdivision 12, is amended to read:

157.13 Subd. 12. **Comprehensive evaluation.** "Comprehensive evaluation" shall consist of:

157.14 (1) a medical report on the health status and physical condition of the proposed ward,
157.15 prepared under the direction of a licensed physician or advanced practice registered nurse;

157.16 (2) a report on the proposed ward's intellectual capacity and functional abilities, specifying
157.17 the tests and other data used in reaching its conclusions, prepared by a psychologist who is
157.18 qualified in the diagnosis of developmental disability; and

157.19 (3) a report from the case manager that includes:

157.20 (i) the most current assessment of individual service needs as described in rules of the
157.21 commissioner;

157.22 (ii) the most current individual service plan under section 256B.092, subdivision 1b;

157.23 and

157.24 (iii) a description of contacts with and responses of near relatives of the proposed ward
157.25 notifying them that a nomination for public guardianship has been made and advising them
157.26 that they may seek private guardianship.

157.27 Each report shall contain recommendations as to the amount of assistance and supervision
157.28 required by the proposed ward to function as independently as possible in society. To be
157.29 considered part of the comprehensive evaluation, reports must be completed no more than
157.30 one year before filing the petition under section 252A.05.

158.1 Sec. 98. Minnesota Statutes 2018, section 252A.04, subdivision 2, is amended to read:

158.2 Subd. 2. **Medication; treatment.** A proposed ward who, at the time the comprehensive
158.3 evaluation is to be performed, has been under medical care shall not be so under the influence
158.4 or so suffer the effects of drugs, medication, or other treatment as to be hampered in the
158.5 testing or evaluation process. When in the opinion of the licensed physician or advanced
158.6 practice registered nurse attending the proposed ward, the discontinuance of medication or
158.7 other treatment is not in the proposed ward's best interest, the physician or advanced practice
158.8 registered nurse shall record a list of all drugs, medication or other treatment which the
158.9 proposed ward received 48 hours immediately prior to any examination, test or interview
158.10 conducted in preparation for the comprehensive evaluation.

158.11 Sec. 99. Minnesota Statutes 2018, section 252A.20, subdivision 1, is amended to read:

158.12 Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01
158.13 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and
158.14 mileage prescribed by law; to each physician, advanced practice registered nurse,
158.15 psychologist, or social worker who assists in the preparation of the comprehensive evaluation
158.16 and who is not in the employ of the local agency or the state Department of Human Services,
158.17 a reasonable sum for services and for travel; and to the ward's counsel, when appointed by
158.18 the court, a reasonable sum for travel and for each day or portion of a day actually employed
158.19 in court or actually consumed in preparing for the hearing. Upon order the county auditor
158.20 shall issue a warrant on the county treasurer for payment of the amount allowed.

158.21 Sec. 100. Minnesota Statutes 2018, section 253B.03, subdivision 4, is amended to read:

158.22 Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a
158.23 personal physician or advanced practice registered nurse, spiritual advisor, and counsel at
158.24 all reasonable times. The patient has the right to continue the practice of religion.

158.25 Sec. 101. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

158.26 Subd. 6d. **Adult mental health treatment.** (a) A competent adult may make a declaration
158.27 of preferences or instructions regarding intrusive mental health treatment. These preferences
158.28 or instructions may include, but are not limited to, consent to or refusal of these treatments.

158.29 (b) A declaration may designate a proxy to make decisions about intrusive mental health
158.30 treatment. A proxy designated to make decisions about intrusive mental health treatments
158.31 and who agrees to serve as proxy may make decisions on behalf of a declarant consistent
158.32 with any desires the declarant expresses in the declaration.

159.1 (c) A declaration is effective only if it is signed by the declarant and two witnesses. The
159.2 witnesses must include a statement that they believe the declarant understands the nature
159.3 and significance of the declaration. A declaration becomes operative when it is delivered
159.4 to the declarant's physician, advanced practice registered nurse, or other mental health
159.5 treatment provider. The physician, advanced practice registered nurse, or provider must
159.6 comply with it to the fullest extent possible, consistent with reasonable medical practice,
159.7 the availability of treatments requested, and applicable law. The physician, advanced practice
159.8 registered nurse, or provider shall continue to obtain the declarant's informed consent to all
159.9 intrusive mental health treatment decisions if the declarant is capable of informed consent.
159.10 A treatment provider may not require a person to make a declaration under this subdivision
159.11 as a condition of receiving services.

159.12 (d) The physician, advanced practice registered nurse, or other provider shall make the
159.13 declaration a part of the declarant's medical record. If the physician, advanced practice
159.14 registered nurse, or other provider is unwilling at any time to comply with the declaration,
159.15 the physician, advanced practice registered nurse, or provider must promptly notify the
159.16 declarant and document the notification in the declarant's medical record. If the declarant
159.17 has been committed as a patient under this chapter, the physician, advanced practice
159.18 registered nurse, or provider may subject a declarant to intrusive treatment in a manner
159.19 contrary to the declarant's expressed wishes, only upon order of the committing court. If
159.20 the declarant is not a committed patient under this chapter, the physician, advanced practice
159.21 registered nurse, or provider may subject the declarant to intrusive treatment in a manner
159.22 contrary to the declarant's expressed wishes, only if the declarant is committed as mentally
159.23 ill or mentally ill and dangerous to the public and a court order authorizing the treatment
159.24 has been issued.

159.25 (e) A declaration under this subdivision may be revoked in whole or in part at any time
159.26 and in any manner by the declarant if the declarant is competent at the time of revocation.
159.27 A revocation is effective when a competent declarant communicates the revocation to the
159.28 attending physician, advanced practice registered nurse, or other provider. The attending
159.29 physician, advanced practice registered nurse, or other provider shall note the revocation
159.30 as part of the declarant's medical record.

159.31 (f) A provider who administers intrusive mental health treatment according to and in
159.32 good faith reliance upon the validity of a declaration under this subdivision is held harmless
159.33 from any liability resulting from a subsequent finding of invalidity.

160.1 (g) In addition to making a declaration under this subdivision, a competent adult may
160.2 delegate parental powers under section 524.5-211 or may nominate a guardian under sections
160.3 524.5-101 to 524.5-502.

160.4 Sec. 102. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

160.5 Subd. 2. **Chemically dependent persons.** Patients hospitalized as chemically dependent
160.6 pursuant to section 253B.04 or 253B.05 shall also be examined within 48 hours of admission.
160.7 At a minimum, the examination shall consist of a physical evaluation by facility staff
160.8 according to procedures established by a physician or advanced practice registered nurse
160.9 and an evaluation by staff knowledgeable and trained in the diagnosis of the alleged disability
160.10 related to the need for admission as a chemically dependent person.

160.11 Sec. 103. Minnesota Statutes 2018, section 253B.23, subdivision 4, is amended to read:

160.12 Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or
160.13 information thought by them to be reliable, who act pursuant to any provision of this chapter
160.14 or who procedurally or physically assist in the commitment of any individual, pursuant to
160.15 this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege
160.16 otherwise existing between patient and physician, patient and advanced practice registered
160.17 nurse, patient and registered nurse, patient and psychologist, patient and examiner, or patient
160.18 and social worker, is waived as to any physician, advanced practice registered nurse,
160.19 registered nurse, psychologist, examiner, or social worker who provides information with
160.20 respect to a patient pursuant to any provision of this chapter.

160.21 Sec. 104. Minnesota Statutes 2018, section 254A.08, subdivision 2, is amended to read:

160.22 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
160.23 program means a social rehabilitation program licensed by the Department of Human
160.24 Services under chapter 245A, and governed by the standards of Minnesota Rules, parts
160.25 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and
160.26 treatment by detoxifying and evaluating the person and providing entrance into a
160.27 comprehensive program. Evaluation of the person shall include verification by a professional,
160.28 after preliminary examination, that the person is intoxicated or has symptoms of substance
160.29 misuse or substance use disorder and appears to be in imminent danger of harming self or
160.30 others. A detoxification program shall have available the services of a licensed physician
160.31 or advanced practice registered nurse for medical emergencies and routine medical
160.32 surveillance. A detoxification program licensed by the Department of Human Services to

161.1 serve both adults and minors at the same site must provide for separate sleeping areas for
161.2 adults and minors.

161.3 Sec. 105. Minnesota Statutes 2018, section 256.9685, subdivision 1a, is amended to read:

161.4 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,
161.5 subdivision 15, the commissioner shall establish an administrative reconsideration process
161.6 for appeals of inpatient hospital services determined to be medically unnecessary. A
161.7 physician, advanced practice registered nurse, or hospital may request a reconsideration of
161.8 the decision that inpatient hospital services are not medically necessary by submitting a
161.9 written request for review to the commissioner within 30 days after receiving notice of the
161.10 decision. The reconsideration process shall take place prior to the procedures of subdivision
161.11 1b and shall be conducted by the medical review agent that is independent of the case under
161.12 reconsideration.

161.13 Sec. 106. Minnesota Statutes 2018, section 256.9685, subdivision 1b, is amended to read:

161.14 Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the
161.15 commissioner may recover inpatient hospital payments for services that have been determined
161.16 to be medically unnecessary after the reconsideration and determinations. A physician,
161.17 advanced practice registered nurse, or hospital may appeal the result of the reconsideration
161.18 process by submitting a written request for review to the commissioner within 30 days after
161.19 receiving notice of the action. The commissioner shall review the medical record and
161.20 information submitted during the reconsideration process and the medical review agent's
161.21 basis for the determination that the services were not medically necessary for inpatient
161.22 hospital services. The commissioner shall issue an order upholding or reversing the decision
161.23 of the reconsideration process based on the review.

161.24 Sec. 107. Minnesota Statutes 2018, section 256.9685, subdivision 1c, is amended to read:

161.25 Subd. 1c. **Judicial review.** A hospital or, physician, or advanced practice registered
161.26 nurse aggrieved by an order of the commissioner under subdivision 1b may appeal the order
161.27 to the district court of the county in which the physician, advanced practice registered nurse,
161.28 or hospital is located by:

161.29 (1) serving a written copy of a notice of appeal upon the commissioner within 30 days
161.30 after the date the commissioner issued the order; and

161.31 (2) filing the original notice of appeal and proof of service with the court administrator
161.32 of the district court. The appeal shall be treated as a dispositive motion under the Minnesota

162.1 General Rules of Practice, rule 115. The district court scope of review shall be as set forth
162.2 in section 14.69.

162.3 Sec. 108. Minnesota Statutes 2018, section 256.975, subdivision 7a, is amended to read:

162.4 Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a)
162.5 All individuals seeking admission to Medicaid-certified nursing facilities, including certified
162.6 boarding care facilities, must be screened prior to admission regardless of income, assets,
162.7 or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs
162.8 (a) and (b). The purpose of the screening is to determine the need for nursing facility level
162.9 of care as described in section 256B.0911, subdivision 4e, and to complete activities required
162.10 under federal law related to mental illness and developmental disability as outlined in
162.11 paragraph (b).

162.12 (b) A person who has a diagnosis or possible diagnosis of mental illness or developmental
162.13 disability must receive a preadmission screening before admission regardless of the
162.14 exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further
162.15 evaluation and specialized services, unless the admission prior to screening is authorized
162.16 by the local mental health authority or the local developmental disabilities case manager,
162.17 or unless authorized by the county agency according to Public Law 101-508.

162.18 (c) The following criteria apply to the preadmission screening:

162.19 (1) requests for preadmission screenings must be submitted via an online form developed
162.20 by the commissioner;

162.21 (2) the Senior LinkAge Line must use forms and criteria developed by the commissioner
162.22 to identify persons who require referral for further evaluation and determination of the need
162.23 for specialized services; and

162.24 (3) the evaluation and determination of the need for specialized services must be done
162.25 by:

162.26 (i) a qualified independent mental health professional, for persons with a primary or
162.27 secondary diagnosis of a serious mental illness; or

162.28 (ii) a qualified developmental disability professional, for persons with a primary or
162.29 secondary diagnosis of developmental disability. For purposes of this requirement, a qualified
162.30 developmental disability professional must meet the standards for a qualified developmental
162.31 disability professional under Code of Federal Regulations, title 42, section 483.430.

163.1 (d) The local county mental health authority or the state developmental disability authority
163.2 under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the
163.3 individual does not meet the nursing facility level of care criteria or needs specialized
163.4 services as defined in Public Laws 100-203 and 101-508. For purposes of this section,
163.5 "specialized services" for a person with developmental disability means active treatment as
163.6 that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

163.7 (e) In assessing a person's needs, the screener shall:

163.8 (1) use an automated system designated by the commissioner;

163.9 (2) consult with care transitions coordinators ~~or~~ physician, or advanced practice registered
163.10 nurse; and

163.11 (3) consider the assessment of the individual's physician or advanced practice registered
163.12 nurse.

163.13 Other personnel may be included in the level of care determination as deemed necessary
163.14 by the screener.

163.15 Sec. 109. Minnesota Statutes 2018, section 256.975, subdivision 11, is amended to read:

163.16 Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging
163.17 shall award competitive grants to eligible applicants for regional and local projects and
163.18 initiatives targeted to a designated community, which may consist of a specific geographic
163.19 area or population, to increase awareness of Alzheimer's disease and other dementias,
163.20 increase the rate of cognitive testing in the population at risk for dementias, promote the
163.21 benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to
163.22 education and resources.

163.23 (b) The project areas for grants include:

163.24 (1) local or community-based initiatives to promote the benefits of physician or advanced
163.25 practice registered nurse consultations for all individuals who suspect a memory or cognitive
163.26 problem;

163.27 (2) local or community-based initiatives to promote the benefits of early diagnosis of
163.28 Alzheimer's disease and other dementias; and

163.29 (3) local or community-based initiatives to provide informational materials and other
163.30 resources to caregivers of persons with dementia.

164.1 (c) Eligible applicants for local and regional grants may include, but are not limited to,
164.2 community health boards, school districts, colleges and universities, community clinics,
164.3 tribal communities, nonprofit organizations, and other health care organizations.

164.4 (d) Applicants must:

164.5 (1) describe the proposed initiative, including the targeted community and how the
164.6 initiative meets the requirements of this subdivision; and

164.7 (2) identify the proposed outcomes of the initiative and the evaluation process to be used
164.8 to measure these outcomes.

164.9 (e) In awarding the regional and local dementia grants, the Minnesota Board on Aging
164.10 must give priority to applicants who demonstrate that the proposed project:

164.11 (1) is supported by and appropriately targeted to the community the applicant serves;

164.12 (2) is designed to coordinate with other community activities related to other health
164.13 initiatives, particularly those initiatives targeted at the elderly;

164.14 (3) is conducted by an applicant able to demonstrate expertise in the project areas;

164.15 (4) utilizes and enhances existing activities and resources or involves innovative
164.16 approaches to achieve success in the project areas; and

164.17 (5) strengthens community relationships and partnerships in order to achieve the project
164.18 areas.

164.19 (f) The board shall divide the state into specific geographic regions and allocate a
164.20 percentage of the money available for the local and regional dementia grants to projects or
164.21 initiatives aimed at each geographic region.

164.22 (g) The board shall award any available grants by January 1, 2016, and each July 1
164.23 thereafter.

164.24 (h) Each grant recipient shall report to the board on the progress of the initiative at least
164.25 once during the grant period, and within two months of the end of the grant period shall
164.26 submit a final report to the board that includes the outcome results.

164.27 (i) The Minnesota Board on Aging shall:

164.28 (1) develop the criteria and procedures to allocate the grants under this subdivision,
164.29 evaluate all applicants on a competitive basis and award the grants, and select qualified
164.30 providers to offer technical assistance to grant applicants and grantees. The selected provider

165.1 shall provide applicants and grantees assistance with project design, evaluation methods,
165.2 materials, and training; and

165.3 (2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on
165.4 the dementia grants programs under this subdivision to the chairs and ranking minority
165.5 members of the senate and house of representatives committees and divisions with jurisdiction
165.6 over health finance and policy. The report shall include:

165.7 (i) information on each grant recipient;

165.8 (ii) a summary of all projects or initiatives undertaken with each grant;

165.9 (iii) the measurable outcomes established by each grantee, an explanation of the
165.10 evaluation process used to determine whether the outcomes were met, and the results of the
165.11 evaluation; and

165.12 (iv) an accounting of how the grant funds were spent.

165.13 Sec. 110. Minnesota Statutes 2018, section 256B.04, subdivision 14a, is amended to read:

165.14 Subd. 14a. **Level of need determination.** Nonemergency medical transportation level
165.15 of need determinations must be performed by a physician, a registered nurse working under
165.16 direct supervision of a physician, a physician assistant, ~~a nurse practitioner~~ an advanced
165.17 practice registered nurse, a licensed practical nurse, or a discharge planner. Nonemergency
165.18 medical transportation level of need determinations must not be performed more than
165.19 annually on any individual, unless the individual's circumstances have sufficiently changed
165.20 so as to require a new level of need determination. Individuals residing in licensed nursing
165.21 facilities are exempt from a level of need determination and are eligible for special
165.22 transportation services until the individual no longer resides in a licensed nursing facility.
165.23 If a person authorized by this subdivision to perform a level of need determination determines
165.24 that an individual requires stretcher transportation, the individual is presumed to maintain
165.25 that level of need until otherwise determined by a person authorized to perform a level of
165.26 need determination, or for six months, whichever is sooner.

165.27 Sec. 111. Minnesota Statutes 2018, section 256B.043, subdivision 2, is amended to read:

165.28 Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part
165.29 of their ongoing duties, shall consider the adequacy of the current system of community
165.30 health clinics and centers both statewide and in urban areas with significant disparities in
165.31 health status and access to services across racial and ethnic groups, including:

165.32 (1) methods to provide 24-hour availability of care through the clinics and centers;

166.1 (2) methods to expand the availability of care through the clinics and centers;

166.2 (3) the use of grants to expand the number of clinics and centers, the services provided,
166.3 and the availability of care; and

166.4 (4) the extent to which increased use of physician assistants, ~~nurse practitioners~~ advanced
166.5 practice registered nurses, medical residents and interns, and other allied health professionals
166.6 in clinics and centers would increase the availability of services.

166.7 (b) The commissioners shall make departmental modifications and legislative
166.8 recommendations as appropriate on the basis of their considerations under paragraph (a).

166.9 Sec. 112. Minnesota Statutes 2018, section 256B.055, subdivision 12, is amended to read:

166.10 Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if
166.11 the person is under age 19 and qualifies as a disabled individual under United States Code,
166.12 title 42, section 1382c(a), and would be eligible for medical assistance under the state plan
166.13 if residing in a medical institution, and the child requires a level of care provided in a hospital,
166.14 nursing facility, or intermediate care facility for persons with developmental disabilities,
166.15 for whom home care is appropriate, provided that the cost to medical assistance under this
166.16 section is not more than the amount that medical assistance would pay for if the child resides
166.17 in an institution. After the child is determined to be eligible under this section, the
166.18 commissioner shall review the child's disability under United States Code, title 42, section
166.19 1382c(a) and level of care defined under this section no more often than annually and may
166.20 elect, based on the recommendation of health care professionals under contract with the
166.21 state medical review team, to extend the review of disability and level of care up to a
166.22 maximum of four years. The commissioner's decision on the frequency of continuing review
166.23 of disability and level of care is not subject to administrative appeal under section 256.045.
166.24 The county agency shall send a notice of disability review to the enrollee six months prior
166.25 to the date the recertification of disability is due. Nothing in this subdivision shall be
166.26 construed as affecting other redeterminations of medical assistance eligibility under this
166.27 chapter and annual cost-effective reviews under this section.

166.28 (b) For purposes of this subdivision, "hospital" means an institution as defined in section
166.29 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and
166.30 licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child
166.31 requires a level of care provided in a hospital if the child is determined by the commissioner
166.32 to need an extensive array of health services, including mental health services, for an
166.33 undetermined period of time, whose health condition requires frequent monitoring and
166.34 treatment by a health care professional or by a person supervised by a health care

167.1 professional, who would reside in a hospital or require frequent hospitalization if these
167.2 services were not provided, and the daily care needs are more complex than a nursing facility
167.3 level of care.

167.4 A child with serious emotional disturbance requires a level of care provided in a hospital
167.5 if the commissioner determines that the individual requires 24-hour supervision because
167.6 the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent
167.7 or frequent psychosomatic disorders or somatopsychic disorders that may become life
167.8 threatening, recurrent or frequent severe socially unacceptable behavior associated with
167.9 psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic
167.10 developmental problems requiring continuous skilled observation, or severe disabling
167.11 symptoms for which office-centered outpatient treatment is not adequate, and which overall
167.12 severely impact the individual's ability to function.

167.13 (c) For purposes of this subdivision, "nursing facility" means a facility which provides
167.14 nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections
167.15 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is
167.16 in need of special treatments provided or supervised by a licensed nurse; or has unpredictable
167.17 episodes of active disease processes requiring immediate judgment by a licensed nurse. For
167.18 purposes of this subdivision, a child requires the level of care provided in a nursing facility
167.19 if the child is determined by the commissioner to meet the requirements of the preadmission
167.20 screening assessment document under section 256B.0911, adjusted to address age-appropriate
167.21 standards for children age 18 and under.

167.22 (d) For purposes of this subdivision, "intermediate care facility for persons with
167.23 developmental disabilities" or "ICF/DD" means a program licensed to provide services to
167.24 persons with developmental disabilities under section 252.28, and chapter 245A, and a
167.25 physical plant licensed as a supervised living facility under chapter 144, which together are
167.26 certified by the Minnesota Department of Health as meeting the standards in Code of Federal
167.27 Regulations, title 42, part 483, for an intermediate care facility which provides services for
167.28 persons with developmental disabilities who require 24-hour supervision and active treatment
167.29 for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child
167.30 requires a level of care provided in an ICF/DD if the commissioner finds that the child has
167.31 a developmental disability in accordance with section 256B.092, is in need of a 24-hour
167.32 plan of care and active treatment similar to persons with developmental disabilities, and
167.33 there is a reasonable indication that the child will need ICF/DD services.

167.34 (e) For purposes of this subdivision, a person requires the level of care provided in a
167.35 nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental

168.1 health treatment because of specific symptoms or functional impairments associated with
168.2 a serious mental illness or disorder diagnosis, which meet severity criteria for mental health
168.3 established by the commissioner and published in March 1997 as the Minnesota Mental
168.4 Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

168.5 (f) The determination of the level of care needed by the child shall be made by the
168.6 commissioner based on information supplied to the commissioner by the parent or guardian,
168.7 the child's physician or physicians or advanced practice registered nurse or advanced practice
168.8 registered nurses, and other professionals as requested by the commissioner. The
168.9 commissioner shall establish a screening team to conduct the level of care determinations
168.10 according to this subdivision.

168.11 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
168.12 must assess the case to determine whether:

168.13 (1) the child qualifies as a disabled individual under United States Code, title 42, section
168.14 1382c(a), and would be eligible for medical assistance if residing in a medical institution;
168.15 and

168.16 (2) the cost of medical assistance services for the child, if eligible under this subdivision,
168.17 would not be more than the cost to medical assistance if the child resides in a medical
168.18 institution to be determined as follows:

168.19 (i) for a child who requires a level of care provided in an ICF/DD, the cost of care for
168.20 the child in an institution shall be determined using the average payment rate established
168.21 for the regional treatment centers that are certified as ICF's/DD;

168.22 (ii) for a child who requires a level of care provided in an inpatient hospital setting
168.23 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
168.24 Rules, part 9505.3520, items F and G; and

168.25 (iii) for a child who requires a level of care provided in a nursing facility according to
168.26 paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules,
168.27 part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates
168.28 which would be paid for children under age 16. The commissioner may authorize an amount
168.29 up to the amount medical assistance would pay for a child referred to the commissioner by
168.30 the preadmission screening team under section 256B.0911.

169.1 Sec. 113. Minnesota Statutes 2018, section 256B.0622, subdivision 2b, is amended to
169.2 read:

169.3 Subd. 2b. **Continuing stay and discharge criteria for assertive community**

169.4 **treatment.** (a) A client receiving assertive community treatment is eligible to continue
169.5 receiving services if:

169.6 (1) the client has not achieved the desired outcomes of their individual treatment plan;

169.7 (2) the client's level of functioning has not been restored, improved, or sustained over
169.8 the time frame outlined in the individual treatment plan;

169.9 (3) the client continues to be at risk for relapse based on current clinical assessment,
169.10 history, or the tenuous nature of the functional gains; or

169.11 (4) the client is functioning effectively with this service and discharge would otherwise
169.12 be indicated but without continued services the client's functioning would decline; and

169.13 (5) one of the following must also apply:

169.14 (i) the client has achieved current individual treatment plan goals but additional goals
169.15 are indicated as evidenced by documented symptoms;

169.16 (ii) the client is making satisfactory progress toward meeting goals and there is
169.17 documentation that supports that continuation of this service shall be effective in addressing
169.18 the goals outlined in the individual treatment plan;

169.19 (iii) the client is making progress, but the specific interventions in the individual treatment
169.20 plan need to be modified so that greater gains, which are consistent with the client's potential
169.21 level of functioning, are possible; or

169.22 (iv) the client fails to make progress or demonstrates regression in meeting goals through
169.23 the interventions outlined in the individual treatment plan.

169.24 (b) Clients receiving assertive community treatment are eligible to be discharged if they
169.25 meet at least one of the following criteria:

169.26 (1) the client and the ACT team determine that assertive community treatment services
169.27 are no longer needed based on the attainment of goals as identified in the individual treatment
169.28 plan and a less intensive level of care would adequately address current goals;

169.29 (2) the client moves out of the ACT team's service area and the ACT team has facilitated
169.30 the referral to either a new ACT team or other appropriate mental health service and has
169.31 assisted the individual in the transition process;

170.1 (3) the client, or the client's legal guardian when applicable, chooses to withdraw from
170.2 assertive community treatment services and documented attempts by the ACT team to
170.3 re-engage the client with the service have not been successful;

170.4 (4) the client has a demonstrated need for a medical nursing home placement lasting
170.5 more than three months, as determined by a physician or advanced practice registered nurse;

170.6 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
170.7 than three months. However, the ACT team must make provisions for the client to return
170.8 to the ACT team upon their discharge or release from the hospital or jail if the client still
170.9 meets eligibility criteria for assertive community treatment and the team is not at full capacity;

170.10 (6) the ACT team is unable to locate, contact, and engage the client for a period of greater
170.11 than three months after persistent efforts by the ACT team to locate the client; or

170.12 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
170.13 team to engage the client in service planning. The ACT team must develop a transition plan
170.14 to arrange for alternate treatment for clients in this situation who have a history of suicide
170.15 attempts, assault, or forensic involvement.

170.16 (c) For all clients who are discharged from assertive community treatment to another
170.17 service provider within the ACT team's service area there is a three-month transfer period,
170.18 from the date of discharge, during which a client who does not adjust well to the new service,
170.19 may voluntarily return to the ACT team. During this period, the ACT team must maintain
170.20 contact with the client's new service provider.

170.21 Sec. 114. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

170.22 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
170.23 given them.

170.24 (a) "Adult rehabilitative mental health services" means mental health services which are
170.25 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
170.26 competencies, personal and emotional adjustment, independent living, parenting skills, and
170.27 community skills, when these abilities are impaired by the symptoms of mental illness.
170.28 Adult rehabilitative mental health services are also appropriate when provided to enable a
170.29 recipient to retain stability and functioning, if the recipient would be at risk of significant
170.30 functional decompensation or more restrictive service settings without these services.

170.31 (1) Adult rehabilitative mental health services instruct, assist, and support the recipient
170.32 in areas such as: interpersonal communication skills, community resource utilization and
170.33 integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting

171.1 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
 171.2 transportation skills, medication education and monitoring, mental illness symptom
 171.3 management skills, household management skills, employment-related skills, parenting
 171.4 skills, and transition to community living services.

171.5 (2) These services shall be provided to the recipient on a one-to-one basis in the recipient's
 171.6 home or another community setting or in groups.

171.7 (b) "Medication education services" means services provided individually or in groups
 171.8 which focus on educating the recipient about mental illness and symptoms; the role and
 171.9 effects of medications in treating symptoms of mental illness; and the side effects of
 171.10 medications. Medication education is coordinated with medication management services
 171.11 and does not duplicate it. Medication education services are provided by physicians, advanced
 171.12 practice registered nurses, pharmacists, physician assistants, or registered nurses.

171.13 (c) "Transition to community living services" means services which maintain continuity
 171.14 of contact between the rehabilitation services provider and the recipient and which facilitate
 171.15 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
 171.16 9505, board and lodging facility, or nursing home. Transition to community living services
 171.17 are not intended to provide other areas of adult rehabilitative mental health services.

171.18 Sec. 115. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to
 171.19 read:

171.20 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers
 171.21 eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed
 171.22 practitioner.

171.23 (b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"
 171.24 includes a physician, an advanced practice registered nurse, or a podiatrist.

171.25 Sec. 116. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is
 171.26 amended to read:

171.27 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
 171.28 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
 171.29 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
 171.30 dispensing physician, or by a physician, a physician assistant, or a nurse practitioner an
 171.31 advanced practice registered nurse employed by or under contract with a community health

172.1 board as defined in section 145A.02, subdivision 5, for the purposes of communicable
172.2 disease control.

172.3 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
172.4 unless authorized by the commissioner.

172.5 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
172.6 ingredient" is defined as a substance that is represented for use in a drug and when used in
172.7 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
172.8 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
172.9 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
172.10 excipients which are included in the medical assistance formulary. Medical assistance covers
172.11 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
172.12 when the compounded combination is specifically approved by the commissioner or when
172.13 a commercially available product:

172.14 (1) is not a therapeutic option for the patient;

172.15 (2) does not exist in the same combination of active ingredients in the same strengths
172.16 as the compounded prescription; and

172.17 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
172.18 prescription.

172.19 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
172.20 a licensed practitioner or by a licensed pharmacist who meets standards established by the
172.21 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
172.22 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
172.23 with documented vitamin deficiencies, vitamins for children under the age of seven and
172.24 pregnant or nursing women, and any other over-the-counter drug identified by the
172.25 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
172.26 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
172.27 disorders, and this determination shall not be subject to the requirements of chapter 14. A
172.28 pharmacist may prescribe over-the-counter medications as provided under this paragraph
172.29 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
172.30 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
172.31 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
172.32 and make referrals as needed to other health care professionals.

172.33 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
172.34 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and

173.1 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
173.2 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
173.3 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
173.4 individuals, medical assistance may cover drugs from the drug classes listed in United States
173.5 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
173.6 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
173.7 not be covered.

173.8 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
173.9 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
173.10 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
173.11 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

173.12 Sec. 117. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is
173.13 amended to read:

173.14 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
173.15 means motor vehicle transportation provided by a public or private person that serves
173.16 Minnesota health care program beneficiaries who do not require emergency ambulance
173.17 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

173.18 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
173.19 emergency medical care or transportation costs incurred by eligible persons in obtaining
173.20 emergency or nonemergency medical care when paid directly to an ambulance company,
173.21 nonemergency medical transportation company, or other recognized providers of
173.22 transportation services. Medical transportation must be provided by:

173.23 (1) nonemergency medical transportation providers who meet the requirements of this
173.24 subdivision;

173.25 (2) ambulances, as defined in section 144E.001, subdivision 2;

173.26 (3) taxicabs that meet the requirements of this subdivision;

173.27 (4) public transit, as defined in section 174.22, subdivision 7; or

173.28 (5) not-for-hire vehicles, including volunteer drivers.

173.29 (c) Medical assistance covers nonemergency medical transportation provided by
173.30 nonemergency medical transportation providers enrolled in the Minnesota health care
173.31 programs. All nonemergency medical transportation providers must comply with the
173.32 operating standards for special transportation service as defined in sections 174.29 to 174.30

174.1 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
174.2 commissioner and reported on the claim as the individual who provided the service. All
174.3 nonemergency medical transportation providers shall bill for nonemergency medical
174.4 transportation services in accordance with Minnesota health care programs criteria. Publicly
174.5 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
174.6 requirements outlined in this paragraph.

174.7 (d) An organization may be terminated, denied, or suspended from enrollment if:

174.8 (1) the provider has not initiated background studies on the individuals specified in
174.9 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

174.10 (2) the provider has initiated background studies on the individuals specified in section
174.11 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

174.12 (i) the commissioner has sent the provider a notice that the individual has been
174.13 disqualified under section 245C.14; and

174.14 (ii) the individual has not received a disqualification set-aside specific to the special
174.15 transportation services provider under sections 245C.22 and 245C.23.

174.16 (e) The administrative agency of nonemergency medical transportation must:

174.17 (1) adhere to the policies defined by the commissioner in consultation with the
174.18 Nonemergency Medical Transportation Advisory Committee;

174.19 (2) pay nonemergency medical transportation providers for services provided to
174.20 Minnesota health care programs beneficiaries to obtain covered medical services;

174.21 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
174.22 trips, and number of trips by mode; and

174.23 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
174.24 administrative structure assessment tool that meets the technical requirements established
174.25 by the commissioner, reconciles trip information with claims being submitted by providers,
174.26 and ensures prompt payment for nonemergency medical transportation services.

174.27 (f) Until the commissioner implements the single administrative structure and delivery
174.28 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
174.29 commissioner or an entity approved by the commissioner that does not dispatch rides for
174.30 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

174.31 (g) The commissioner may use an order by the recipient's attending physician, advanced
174.32 practice registered nurse, or a medical or mental health professional to certify that the

175.1 recipient requires nonemergency medical transportation services. Nonemergency medical
175.2 transportation providers shall perform driver-assisted services for eligible individuals, when
175.3 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
175.4 residence or place of business, assistance with admittance of the individual to the medical
175.5 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
175.6 or stretchers in the vehicle.

175.7 Nonemergency medical transportation providers must take clients to the health care
175.8 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
175.9 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
175.10 authorization from the local agency.

175.11 Nonemergency medical transportation providers may not bill for separate base rates for
175.12 the continuation of a trip beyond the original destination. Nonemergency medical
175.13 transportation providers must maintain trip logs, which include pickup and drop-off times,
175.14 signed by the medical provider or client, whichever is deemed most appropriate, attesting
175.15 to mileage traveled to obtain covered medical services. Clients requesting client mileage
175.16 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
175.17 services.

175.18 (h) The administrative agency shall use the level of service process established by the
175.19 commissioner in consultation with the Nonemergency Medical Transportation Advisory
175.20 Committee to determine the client's most appropriate mode of transportation. If public transit
175.21 or a certified transportation provider is not available to provide the appropriate service mode
175.22 for the client, the client may receive a onetime service upgrade.

175.23 (i) The covered modes of transportation are:

175.24 (1) client reimbursement, which includes client mileage reimbursement provided to
175.25 clients who have their own transportation, or to family or an acquaintance who provides
175.26 transportation to the client;

175.27 (2) volunteer transport, which includes transportation by volunteers using their own
175.28 vehicle;

175.29 (3) unassisted transport, which includes transportation provided to a client by a taxicab
175.30 or public transit. If a taxicab or public transit is not available, the client can receive
175.31 transportation from another nonemergency medical transportation provider;

175.32 (4) assisted transport, which includes transport provided to clients who require assistance
175.33 by a nonemergency medical transportation provider;

176.1 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
176.2 dependent on a device and requires a nonemergency medical transportation provider with
176.3 a vehicle containing a lift or ramp;

176.4 (6) protected transport, which includes transport provided to a client who has received
176.5 a prescreening that has deemed other forms of transportation inappropriate and who requires
176.6 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
176.7 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
176.8 the vehicle driver; and (ii) who is certified as a protected transport provider; and

176.9 (7) stretcher transport, which includes transport for a client in a prone or supine position
176.10 and requires a nonemergency medical transportation provider with a vehicle that can transport
176.11 a client in a prone or supine position.

176.12 (j) The local agency shall be the single administrative agency and shall administer and
176.13 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
176.14 commissioner has developed, made available, and funded the web-based single administrative
176.15 structure, assessment tool, and level of need assessment under subdivision 18e. The local
176.16 agency's financial obligation is limited to funds provided by the state or federal government.

176.17 (k) The commissioner shall:

176.18 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
176.19 verify that the mode and use of nonemergency medical transportation is appropriate;

176.20 (2) verify that the client is going to an approved medical appointment; and

176.21 (3) investigate all complaints and appeals.

176.22 (l) The administrative agency shall pay for the services provided in this subdivision and
176.23 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
176.24 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
176.25 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

176.26 (m) Payments for nonemergency medical transportation must be paid based on the client's
176.27 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
176.28 medical assistance reimbursement rates for nonemergency medical transportation services
176.29 that are payable by or on behalf of the commissioner for nonemergency medical
176.30 transportation services are:

176.31 (1) \$0.22 per mile for client reimbursement;

177.1 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
177.2 transport;

177.3 (3) equivalent to the standard fare for unassisted transport when provided by public
177.4 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
177.5 medical transportation provider;

177.6 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

177.7 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

177.8 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

177.9 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
177.10 an additional attendant if deemed medically necessary.

177.11 (n) The base rate for nonemergency medical transportation services in areas defined
177.12 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
177.13 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
177.14 services in areas defined under RUCA to be rural or super rural areas is:

177.15 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
177.16 rate in paragraph (m), clauses (1) to (7); and

177.17 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
177.18 rate in paragraph (m), clauses (1) to (7).

177.19 (o) For purposes of reimbursement rates for nonemergency medical transportation
177.20 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
177.21 shall determine whether the urban, rural, or super rural reimbursement rate applies.

177.22 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
177.23 a census-tract based classification system under which a geographical area is determined
177.24 to be urban, rural, or super rural.

177.25 (q) The commissioner, when determining reimbursement rates for nonemergency medical
177.26 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
177.27 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

177.28 Sec. 118. Minnesota Statutes 2018, section 256B.0625, subdivision 26, is amended to
177.29 read:

177.30 Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary
177.31 in making a determination for eligibility for individualized education program and

178.1 individualized family service plan services and for medical services identified in a recipient's
178.2 individualized education program and individualized family service plan and covered under
178.3 the medical assistance state plan. Covered services include occupational therapy, physical
178.4 therapy, speech-language therapy, clinical psychological services, nursing services, school
178.5 psychological services, school social work services, personal care assistants serving as
178.6 management aides, assistive technology devices, transportation services, health assessments,
178.7 and other services covered under the medical assistance state plan. Mental health services
178.8 eligible for medical assistance reimbursement must be provided or coordinated through a
178.9 children's mental health collaborative where a collaborative exists if the child is included
178.10 in the collaborative operational target population. The provision or coordination of services
178.11 does not require that the individualized education program be developed by the collaborative.

178.12 The services may be provided by a Minnesota school district that is enrolled as a medical
178.13 assistance provider or its subcontractor, and only if the services meet all the requirements
178.14 otherwise applicable if the service had been provided by a provider other than a school
178.15 district, in the following areas: medical necessity, physician's or advanced practice registered
178.16 nurse's orders, documentation, personnel qualifications, and prior authorization requirements.
178.17 The nonfederal share of costs for services provided under this subdivision is the responsibility
178.18 of the local school district as provided in section 125A.74. Services listed in a child's
178.19 individualized education program are eligible for medical assistance reimbursement only
178.20 if those services meet criteria for federal financial participation under the Medicaid program.

178.21 (b) Approval of health-related services for inclusion in the individualized education
178.22 program does not require prior authorization for purposes of reimbursement under this
178.23 chapter. The commissioner may require physician or advanced practice registered nurse
178.24 review and approval of the plan not more than once annually or upon any modification of
178.25 the individualized education program that reflects a change in health-related services.

178.26 (c) Services of a speech-language pathologist provided under this section are covered
178.27 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

178.28 (1) holds a masters degree in speech-language pathology;

178.29 (2) is licensed by the Professional Educator Licensing and Standards Board as an
178.30 educational speech-language pathologist; and

178.31 (3) either has a certificate of clinical competence from the American Speech and Hearing
178.32 Association, has completed the equivalent educational requirements and work experience
178.33 necessary for the certificate or has completed the academic program and is acquiring
178.34 supervised work experience to qualify for the certificate.

179.1 (d) Medical assistance coverage for medically necessary services provided under other
 179.2 subdivisions in this section may not be denied solely on the basis that the same or similar
 179.3 services are covered under this subdivision.

179.4 (e) The commissioner shall develop and implement package rates, bundled rates, or per
 179.5 diem rates for special education services under which separately covered services are grouped
 179.6 together and billed as a unit in order to reduce administrative complexity.

179.7 (f) The commissioner shall develop a cost-based payment structure for payment of these
 179.8 services. Only costs reported through the designated Minnesota Department of Education
 179.9 data systems in distinct service categories qualify for inclusion in the cost-based payment
 179.10 structure. The commissioner shall reimburse claims submitted based on an interim rate, and
 179.11 shall settle at a final rate once the department has determined it. The commissioner shall
 179.12 notify the school district of the final rate. The school district has 60 days to appeal the final
 179.13 rate. To appeal the final rate, the school district shall file a written appeal request to the
 179.14 commissioner within 60 days of the date the final rate determination was mailed. The appeal
 179.15 request shall specify (1) the disputed items and (2) the name and address of the person to
 179.16 contact regarding the appeal.

179.17 (g) Effective July 1, 2000, medical assistance services provided under an individualized
 179.18 education program or an individual family service plan by local school districts shall not
 179.19 count against medical assistance authorization thresholds for that child.

179.20 (h) Nursing services as defined in section 148.171, subdivision 15, and provided as an
 179.21 individualized education program health-related service, are eligible for medical assistance
 179.22 payment if they are otherwise a covered service under the medical assistance program.
 179.23 Medical assistance covers the administration of prescription medications by a licensed nurse
 179.24 who is employed by or under contract with a school district when the administration of
 179.25 medications is identified in the child's individualized education program. The simple
 179.26 administration of medications alone is not covered under medical assistance when
 179.27 administered by a provider other than a school district or when it is not identified in the
 179.28 child's individualized education program.

179.29 Sec. 119. Minnesota Statutes 2018, section 256B.0625, subdivision 28, is amended to
 179.30 read:

179.31 Subd. 28. ~~Certified nurse practitioner~~ Advanced practice registered nurse
 179.32 **services.** Medical assistance covers services performed by a certified pediatric nurse
 179.33 ~~practitioner~~ advanced practice registered nurse, a certified family ~~nurse practitioner~~ advanced
 179.34 practice registered nurse, a certified adult ~~nurse practitioner~~ advanced practice registered

180.1 ~~nurse~~, a certified obstetric/gynecological ~~nurse-practitioner~~ advanced practice registered
180.2 nurse, a certified neonatal ~~nurse-practitioner~~ advanced practice registered nurse, or a certified
180.3 geriatric ~~nurse-practitioner~~ advanced practice registered nurse in independent practice, if:

180.4 (1) the service provided on an inpatient basis is not included as part of the cost for
180.5 inpatient services included in the operating payment rate;

180.6 (2) the service is otherwise covered under this chapter as a physician service; and

180.7 (3) the service is within the scope of practice of the ~~nurse-practitioner's~~ advanced practice
180.8 registered nurse's license as a registered nurse, as defined in section 148.171.

180.9 Sec. 120. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is
180.10 amended to read:

180.11 Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance
180.12 covers services provided by a community emergency medical technician (CEMT) who is
180.13 certified under section 144E.275, subdivision 7, when the services are provided in accordance
180.14 with this subdivision.

180.15 (b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled
180.16 nursing facility, when ordered by a treating physician or advanced practice registered nurse.
180.17 The postdischarge visit includes:

180.18 (1) verbal or visual reminders of discharge orders;

180.19 (2) recording and reporting of vital signs to the patient's primary care provider;

180.20 (3) medication access confirmation;

180.21 (4) food access confirmation; and

180.22 (5) identification of home hazards.

180.23 (c) An individual who has repeat ambulance calls due to falls or has been identified by
180.24 the individual's primary care provider as at risk for nursing home placement, may receive
180.25 a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance
180.26 with the individual's care plan. A safety evaluation visit includes:

180.27 (1) medication access confirmation;

180.28 (2) food access confirmation; and

180.29 (3) identification of home hazards.

181.1 (d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit
181.2 may not be billed for the same day as a postdischarge visit for the same individual.

181.3 Sec. 121. Minnesota Statutes 2018, section 256B.0654, subdivision 1, is amended to read:

181.4 Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing
181.5 services provided to recipients who meet the criteria for regular home care nursing and
181.6 require life-sustaining interventions to reduce the risk of long-term injury or death.

181.7 (b) "Home care nursing" means ongoing ~~physician-ordered~~ hourly nursing ordered by
181.8 a physician or advanced practice registered nurse and services performed by a registered
181.9 nurse or licensed practical nurse within the scope of practice as defined by the Minnesota
181.10 Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a
181.11 person's health.

181.12 (c) "Home care nursing agency" means a medical assistance enrolled provider licensed
181.13 under chapter 144A to provide home care nursing services.

181.14 (d) "Regular home care nursing" means home care nursing provided because:

181.15 (1) the recipient requires more individual and continuous care than can be provided
181.16 during a skilled nurse visit; or

181.17 (2) the cares are outside of the scope of services that can be provided by a home health
181.18 aide or personal care assistant.

181.19 (e) "Shared home care nursing" means the provision of home care nursing services by
181.20 a home care nurse to two recipients at the same time and in the same setting.

181.21 Sec. 122. Minnesota Statutes 2018, section 256B.0654, subdivision 2a, is amended to
181.22 read:

181.23 Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

181.24 (1) in the recipient's home or outside the home when normal life activities require;

181.25 (2) when the recipient requires more individual and continuous care than can be provided
181.26 during a skilled nurse visit; and

181.27 (3) when the care required is outside of the scope of services that can be provided by a
181.28 home health aide or personal care assistant.

181.29 (b) Home care nursing services must be:

181.30 (1) assessed by a registered nurse on a form approved by the commissioner;

182.1 (2) ordered by a physician or advanced practice registered nurse and documented in a
182.2 plan of care that is reviewed by the physician at least once every 60 days; and
182.3 (3) authorized by the commissioner under section 256B.0652.

182.4 Sec. 123. Minnesota Statutes 2018, section 256B.0654, subdivision 3, is amended to read:

182.5 Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared
182.6 home care nursing services by a home care nurse shall be limited according to this
182.7 subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory
182.8 provisions relating to home care nursing services apply to shared home care nursing services.
182.9 Nothing in this subdivision shall be construed to reduce the total number of home care
182.10 nursing hours authorized for an individual recipient.

182.11 (b) Shared home care nursing is the provision of nursing services by a home care nurse
182.12 to two medical assistance eligible recipients at the same time and in the same setting. This
182.13 subdivision does not apply when a home care nurse is caring for multiple recipients in more
182.14 than one setting.

182.15 (c) For the purposes of this subdivision, "setting" means:

182.16 (1) the home residence or foster care home of one of the individual recipients as defined
182.17 in section 256B.0651;

182.18 (2) a child care program licensed under chapter 245A or operated by a local school
182.19 district or private school;

182.20 (3) an adult day care service licensed under chapter 245A; or

182.21 (4) outside the home residence or foster care home of one of the recipients when normal
182.22 life activities take the recipients outside the home.

182.23 (d) The home care nursing agency must offer the recipient the option of shared or
182.24 one-on-one home care nursing services. The recipient may withdraw from participating in
182.25 a shared service arrangement at any time.

182.26 (e) The recipient or the recipient's legal representative, and the recipient's physician or
182.27 advanced practice registered nurse, in conjunction with the home care nursing agency, shall
182.28 determine:

182.29 (1) whether shared home care nursing care is an appropriate option based on the individual
182.30 needs and preferences of the recipient; and

183.1 (2) the amount of shared home care nursing services authorized as part of the overall
183.2 authorization of nursing services.

183.3 (f) The recipient or the recipient's legal representative, in conjunction with the home
183.4 care nursing agency, shall approve the setting, grouping, and arrangement of shared home
183.5 care nursing care based on the individual needs and preferences of the recipients. Decisions
183.6 on the selection of recipients to share services must be based on the ages of the recipients,
183.7 compatibility, and coordination of their care needs.

183.8 (g) The following items must be considered by the recipient or the recipient's legal
183.9 representative and the home care nursing agency, and documented in the recipient's health
183.10 service record:

183.11 (1) the additional training needed by the home care nurse to provide care to two recipients
183.12 in the same setting and to ensure that the needs of the recipients are met appropriately and
183.13 safely;

183.14 (2) the setting in which the shared home care nursing care will be provided;

183.15 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of
183.16 the service and process used to make changes in service or setting;

183.17 (4) a contingency plan which accounts for absence of the recipient in a shared home
183.18 care nursing setting due to illness or other circumstances;

183.19 (5) staffing backup contingencies in the event of employee illness or absence; and

183.20 (6) arrangements for additional assistance to respond to urgent or emergency care needs
183.21 of the recipients.

183.22 (h) The documentation for shared home care nursing must be on a form approved by
183.23 the commissioner for each individual recipient sharing home care nursing. The documentation
183.24 must be part of the recipient's health service record and include:

183.25 (1) permission by the recipient or the recipient's legal representative for the maximum
183.26 number of shared nursing hours per week chosen by the recipient and permission for shared
183.27 home care nursing services provided in and outside the recipient's home residence;

183.28 (2) revocation by the recipient or the recipient's legal representative for the shared home
183.29 care nursing permission, or services provided to others in and outside the recipient's
183.30 residence; and

183.31 (3) daily documentation of the shared home care nursing services provided by each
183.32 identified home care nurse, including:

- 184.1 (i) the names of each recipient receiving shared home care nursing services;
- 184.2 (ii) the setting for the shared services, including the starting and ending times that the
- 184.3 recipient received shared home care nursing care; and
- 184.4 (iii) notes by the home care nurse regarding changes in the recipient's condition, problems
- 184.5 that may arise from the sharing of home care nursing services, and scheduling and care
- 184.6 issues.

- 184.7 (i) The commissioner shall provide a rate methodology for shared home care nursing.
- 184.8 For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times
- 184.9 the regular home care nursing rates paid for serving a single individual by a registered nurse
- 184.10 or licensed practical nurse. These rates apply only to situations in which both recipients are
- 184.11 present and receive shared home care nursing care on the date for which the service is billed.

184.12 Sec. 124. Minnesota Statutes 2018, section 256B.0654, subdivision 4, is amended to read:

184.13 **Subd. 4. Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary

184.14 services that require specialized nursing skills and are provided by parents of minor children,

184.15 family foster parents, spouses, and legal guardians who are providing home care nursing

184.16 care under the following conditions:

184.17 (1) the provision of these services is not legally required of the parents, spouses, or legal

184.18 guardians;

184.19 (2) the services are necessary to prevent hospitalization of the recipient; and

184.20 (3) the recipient is eligible for state plan home care or a home and community-based

184.21 waiver and one of the following hardship criteria are met:

184.22 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to

184.23 provide nursing care for the recipient;

184.24 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with

184.25 less compensation to provide nursing care for the recipient;

184.26 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide

184.27 nursing care for the recipient; or

184.28 (iv) because of labor conditions, special language needs, or intermittent hours of care

184.29 needed, the parent, spouse, or legal guardian is needed in order to provide adequate home

184.30 care nursing services to meet the medical needs of the recipient.

185.1 (b) Home care nursing may be provided by a parent, spouse, family foster parent, or
185.2 legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided
185.3 by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing
185.4 services covered and available under liable third-party payors, including Medicare. The
185.5 home care nursing provided by a parent, spouse, family foster parent, or legal guardian must
185.6 be included in the service agreement. Authorized nursing services for a single recipient or
185.7 recipients with the same residence and provided by the parent, spouse, family foster parent,
185.8 or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight
185.9 hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents,
185.10 spouse, family foster parent, or legal guardian shall not provide more than 40 hours of
185.11 services in a seven-day period. For parents, family foster parents, and legal guardians, 40
185.12 hours is the total amount allowed regardless of the number of children or adults who receive
185.13 services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's
185.14 obligation of assuming the nonreimbursed family responsibilities of emergency backup
185.15 caregiver and primary caregiver.

185.16 (c) A parent, family foster parent, or a spouse may not be paid to provide home care
185.17 nursing care if:

185.18 (1) the parent or spouse fails to pass a criminal background check according to chapter
185.19 245C;

185.20 (2) it has been determined by the home care nursing agency, the case manager, or the
185.21 physician or advanced practice registered nurse that the home care nursing provided by the
185.22 parent, family foster parent, spouse, or legal guardian is unsafe; or

185.23 (3) the parent, family foster parent, spouse, or legal guardian does not follow physician
185.24 or advanced practice registered nurse orders.

185.25 (d) For purposes of this section, "assessment" means a review and evaluation of a
185.26 recipient's need for home care services conducted in person. Assessments for home care
185.27 nursing must be conducted by a registered nurse.

185.28 Sec. 125. Minnesota Statutes 2018, section 256B.0659, subdivision 2, is amended to read:

185.29 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
185.30 assistance services eligible for payment include services and supports furnished to an
185.31 individual, as needed, to assist in:

185.32 (1) activities of daily living;

185.33 (2) health-related procedures and tasks;

- 186.1 (3) observation and redirection of behaviors; and
- 186.2 (4) instrumental activities of daily living.
- 186.3 (b) Activities of daily living include the following covered services:
- 186.4 (1) dressing, including assistance with choosing, application, and changing of clothing
- 186.5 and application of special appliances, wraps, or clothing;
- 186.6 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
- 186.7 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
- 186.8 except for recipients who are diabetic or have poor circulation;
- 186.9 (3) bathing, including assistance with basic personal hygiene and skin care;
- 186.10 (4) eating, including assistance with hand washing and application of orthotics required
- 186.11 for eating, transfers, and feeding;
- 186.12 (5) transfers, including assistance with transferring the recipient from one seating or
- 186.13 reclining area to another;
- 186.14 (6) mobility, including assistance with ambulation, including use of a wheelchair.
- 186.15 Mobility does not include providing transportation for a recipient;
- 186.16 (7) positioning, including assistance with positioning or turning a recipient for necessary
- 186.17 care and comfort; and
- 186.18 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
- 186.19 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
- 186.20 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
- 186.21 clothing.
- 186.22 (c) Health-related procedures and tasks include the following covered services:
- 186.23 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
- 186.24 functioning;
- 186.25 (2) assistance with self-administered medication as defined by this section, including
- 186.26 reminders to take medication, bringing medication to the recipient, and assistance with
- 186.27 opening medication under the direction of the recipient or responsible party, including
- 186.28 medications given through a nebulizer;
- 186.29 (3) interventions for seizure disorders, including monitoring and observation; and
- 186.30 (4) other activities considered within the scope of the personal care service and meeting
- 186.31 the definition of health-related procedures and tasks under this section.

187.1 (d) A personal care assistant may provide health-related procedures and tasks associated
187.2 with the complex health-related needs of a recipient if the procedures and tasks meet the
187.3 definition of health-related procedures and tasks under this section and the personal care
187.4 assistant is trained by a qualified professional and demonstrates competency to safely
187.5 complete the procedures and tasks. Delegation of health-related procedures and tasks and
187.6 all training must be documented in the personal care assistance care plan and the recipient's
187.7 and personal care assistant's files. A personal care assistant must not determine the medication
187.8 dose or time for medication.

187.9 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
187.10 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
187.11 support there must be:

187.12 (1) delegation and training by a registered nurse, advanced practice registered nurse,
187.13 certified or licensed respiratory therapist, or a physician;

187.14 (2) utilization of clean rather than sterile procedure;

187.15 (3) specialized training about the health-related procedures and tasks and equipment,
187.16 including ventilator operation and maintenance;

187.17 (4) individualized training regarding the needs of the recipient; and

187.18 (5) supervision by a qualified professional who is a registered nurse.

187.19 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
187.20 recipient for episodes where there is a need for redirection due to behaviors. Training of
187.21 the personal care assistant must occur based on the needs of the recipient, the personal care
187.22 assistance care plan, and any other support services provided.

187.23 (g) Instrumental activities of daily living under subdivision 1, paragraph (i).

187.24 Sec. 126. Minnesota Statutes 2018, section 256B.0659, subdivision 4, is amended to read:

187.25 **Subd. 4. Assessment for personal care assistance services; limitations.** (a) An
187.26 assessment as defined in subdivision 3a must be completed for personal care assistance
187.27 services.

187.28 (b) The following limitations apply to the assessment:

187.29 (1) a person must be assessed as dependent in an activity of daily living based on the
187.30 person's daily need or need on the days during the week the activity is completed for:

187.31 (i) cuing and constant supervision to complete the task; or

188.1 (ii) hands-on assistance to complete the task; and

188.2 (2) a child may not be found to be dependent in an activity of daily living if because of
188.3 the child's age an adult would either perform the activity for the child or assist the child
188.4 with the activity. Assistance needed is the assistance appropriate for a typical child of the
188.5 same age.

188.6 (c) Assessment for complex health-related needs must meet the criteria in this paragraph.
188.7 A recipient qualifies as having complex health-related needs if the recipient has one or more
188.8 of the interventions that are ordered by a physician or advanced practice registered nurse,
188.9 specified in a personal care assistance care plan or community support plan developed under
188.10 section 256B.0911, and found in the following:

188.11 (1) tube feedings requiring:

188.12 (i) a gastrojejunostomy tube; or

188.13 (ii) continuous tube feeding lasting longer than 12 hours per day;

188.14 (2) wounds described as:

188.15 (i) stage III or stage IV;

188.16 (ii) multiple wounds;

188.17 (iii) requiring sterile or clean dressing changes or a wound vac; or

188.18 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
188.19 care;

188.20 (3) parenteral therapy described as:

188.21 (i) IV therapy more than two times per week lasting longer than four hours for each
188.22 treatment; or

188.23 (ii) total parenteral nutrition (TPN) daily;

188.24 (4) respiratory interventions, including:

188.25 (i) oxygen required more than eight hours per day;

188.26 (ii) respiratory vest more than one time per day;

188.27 (iii) bronchial drainage treatments more than two times per day;

188.28 (iv) sterile or clean suctioning more than six times per day;

188.29 (v) dependence on another to apply respiratory ventilation augmentation devices such
188.30 as BiPAP and CPAP; and

- 189.1 (vi) ventilator dependence under section 256B.0652;
- 189.2 (5) insertion and maintenance of catheter, including:
- 189.3 (i) sterile catheter changes more than one time per month;
- 189.4 (ii) clean intermittent catheterization, and including self-catheterization more than six
- 189.5 times per day; or
- 189.6 (iii) bladder irrigations;
- 189.7 (6) bowel program more than two times per week requiring more than 30 minutes to
- 189.8 perform each time;
- 189.9 (7) neurological intervention, including:
- 189.10 (i) seizures more than two times per week and requiring significant physical assistance
- 189.11 to maintain safety; or
- 189.12 (ii) swallowing disorders diagnosed by a physician or advanced practice registered nurse
- 189.13 and requiring specialized assistance from another on a daily basis; and
- 189.14 (8) other congenital or acquired diseases creating a need for significantly increased direct
- 189.15 hands-on assistance and interventions in six to eight activities of daily living.
- 189.16 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
- 189.17 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
- 189.18 assistance at least four times per week and shows one or more of the following behaviors:
- 189.19 (1) physical aggression towards self or others, or destruction of property that requires
- 189.20 the immediate response of another person;
- 189.21 (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
- 189.22 or
- 189.23 (3) increased need for assistance for recipients who are verbally aggressive or resistive
- 189.24 to care so that the time needed to perform activities of daily living is increased.

189.25 Sec. 127. Minnesota Statutes 2018, section 256B.0659, subdivision 8, is amended to read:

189.26 Subd. 8. **Communication with recipient's physician or advanced practice registered**

189.27 **nurse.** The personal care assistance program requires communication with the recipient's

189.28 physician or advanced practice registered nurse about a recipient's assessed needs for personal

189.29 care assistance services. The commissioner shall work with the state medical director to

189.30 develop options for communication with the recipient's physician or advanced practice

189.31 registered nurse.

190.1 Sec. 128. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is
190.2 amended to read:

190.3 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
190.4 meet the following requirements:

190.5 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
190.6 age with these additional requirements:

190.7 (i) supervision by a qualified professional every 60 days; and

190.8 (ii) employment by only one personal care assistance provider agency responsible for
190.9 compliance with current labor laws;

190.10 (2) be employed by a personal care assistance provider agency;

190.11 (3) enroll with the department as a personal care assistant after clearing a background
190.12 study. Except as provided in subdivision 11a, before a personal care assistant provides
190.13 services, the personal care assistance provider agency must initiate a background study on
190.14 the personal care assistant under chapter 245C, and the personal care assistance provider
190.15 agency must have received a notice from the commissioner that the personal care assistant
190.16 is:

190.17 (i) not disqualified under section 245C.14; or

190.18 (ii) disqualified, but the personal care assistant has received a set aside of the
190.19 disqualification under section 245C.22;

190.20 (4) be able to effectively communicate with the recipient and personal care assistance
190.21 provider agency;

190.22 (5) be able to provide covered personal care assistance services according to the recipient's
190.23 personal care assistance care plan, respond appropriately to recipient needs, and report
190.24 changes in the recipient's condition to the supervising qualified professional ~~or~~ physician,
190.25 or advanced practice registered nurse;

190.26 (6) not be a consumer of personal care assistance services;

190.27 (7) maintain daily written records including, but not limited to, time sheets under
190.28 subdivision 12;

190.29 (8) effective January 1, 2010, complete standardized training as determined by the
190.30 commissioner before completing enrollment. The training must be available in languages
190.31 other than English and to those who need accommodations due to disabilities. Personal care
190.32 assistant training must include successful completion of the following training components:

191.1 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
191.2 roles and responsibilities of personal care assistants including information about assistance
191.3 with lifting and transfers for recipients, emergency preparedness, orientation to positive
191.4 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
191.5 training components, the personal care assistant must demonstrate the competency to provide
191.6 assistance to recipients;

191.7 (9) complete training and orientation on the needs of the recipient; and

191.8 (10) be limited to providing and being paid for up to 275 hours per month of personal
191.9 care assistance services regardless of the number of recipients being served or the number
191.10 of personal care assistance provider agencies enrolled with. The number of hours worked
191.11 per day shall not be disallowed by the department unless in violation of the law.

191.12 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
191.13 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

191.14 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
191.15 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
191.16 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
191.17 a residential setting.

191.18 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
191.19 17a if the personal care assistant providing the services:

191.20 (1) provides covered services to a recipient who qualifies for 12 or more hours per day
191.21 of personal care assistance services; and

191.22 (2) satisfies the current requirements of Medicare for training and competency or
191.23 competency evaluation of home health aides or nursing assistants, as provided in the Code
191.24 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved
191.25 training or competency requirements.

191.26 Sec. 129. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is
191.27 amended to read:

191.28 Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The
191.29 case manager shall implement the coordinated service and support plan for each alternative
191.30 care client and ensure that a client's service needs and eligibility are reassessed at least every
191.31 12 months. The coordinated service and support plan must meet the requirements in section
191.32 256S.10. The plan shall include any services prescribed by the individual's attending
191.33 physician or advanced practice registered nurse as necessary to allow the individual to

192.1 remain in a community setting. In developing the individual's care plan, the case manager
192.2 should include the use of volunteers from families and neighbors, religious organizations,
192.3 social clubs, and civic and service organizations to support the formal home care services.
192.4 The lead agency shall be held harmless for damages or injuries sustained through the use
192.5 of volunteers under this subdivision including workers' compensation liability. The case
192.6 manager shall provide documentation in each individual's plan and, if requested, to the
192.7 commissioner that the most cost-effective alternatives available have been offered to the
192.8 individual and that the individual was free to choose among available qualified providers,
192.9 both public and private, including qualified case management or service coordination
192.10 providers other than those employed by any county; however, the county or tribe maintains
192.11 responsibility for prior authorizing services in accordance with statutory and administrative
192.12 requirements. The case manager must give the individual a ten-day written notice of any
192.13 denial, termination, or reduction of alternative care services.

192.14 (b) The county of service or tribe must provide access to and arrange for case management
192.15 services, including assuring implementation of the coordinated service and support plan.
192.16 "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart
192.17 11. The county of service must notify the county of financial responsibility of the approved
192.18 care plan and the amount of encumbered funds.

192.19 Sec. 130. Minnesota Statutes 2018, section 256B.73, subdivision 5, is amended to read:

192.20 Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider
192.21 shall receive a health services benefit package that includes health services which the
192.22 enrollees might reasonably require to be maintained in good health, including emergency
192.23 care, inpatient hospital and physician or advanced practice registered nurse care, outpatient
192.24 health services, and preventive health services.

192.25 (b) Services related to chemical dependency, mental illness, vision care, dental care,
192.26 and other benefits may be excluded or limited upon approval by the commissioners. The
192.27 coalition may petition the commissioner of commerce or health, whichever is appropriate,
192.28 for waivers that allow these benefits to be excluded or limited.

192.29 (c) The commissioners, the coalition, and demonstration providers shall work together
192.30 to design a package of benefits or packages of benefits that can be provided to enrollees for
192.31 an affordable monthly premium.

193.1 Sec. 131. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:

193.2 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a
193.3 "qualified professional" means a licensed physician, a physician assistant, ~~a nurse practitioner~~
193.4 an advanced practice registered nurse, or a licensed chiropractor.

193.5 (b) For developmental disability and intelligence testing, a "qualified professional"
193.6 means an individual qualified by training and experience to administer the tests necessary
193.7 to make determinations, such as tests of intellectual functioning, assessments of adaptive
193.8 behavior, adaptive skills, and developmental functioning. These professionals include
193.9 licensed psychologists, certified school psychologists, or certified psychometrists working
193.10 under the supervision of a licensed psychologist.

193.11 (c) For learning disabilities, a "qualified professional" means a licensed psychologist or
193.12 school psychologist with experience determining learning disabilities.

193.13 (d) For mental health, a "qualified professional" means a licensed physician or a qualified
193.14 mental health professional. A "qualified mental health professional" means:

193.15 (1) for children, in psychiatric nursing, a registered nurse or advanced practice registered
193.16 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
193.17 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
193.18 certification organization or who has a master's degree in nursing or one of the behavioral
193.19 sciences or related fields from an accredited college or university or its equivalent, with at
193.20 least 4,000 hours of post-master's supervised experience in the delivery of clinical services
193.21 in the treatment of mental illness;

193.22 (2) for adults, in psychiatric nursing, a registered nurse or advanced practice registered
193.23 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
193.24 specialist in adult psychiatric and mental health nursing by a national nurse certification
193.25 organization or who has a master's degree in nursing or one of the behavioral sciences or
193.26 related fields from an accredited college or university or its equivalent, with at least 4,000
193.27 hours of post-master's supervised experience in the delivery of clinical services in the
193.28 treatment of mental illness;

193.29 (3) in clinical social work, a person licensed as an independent clinical social worker
193.30 under chapter 148D, or a person with a master's degree in social work from an accredited
193.31 college or university, with at least 4,000 hours of post-master's supervised experience in
193.32 the delivery of clinical services in the treatment of mental illness;

194.1 (4) in psychology, an individual licensed by the Board of Psychology under sections
194.2 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis
194.3 and treatment of mental illness;

194.4 (5) in psychiatry, a physician licensed under chapter 147 and certified by the American
194.5 Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

194.6 (6) in marriage and family therapy, the mental health professional must be a marriage
194.7 and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of
194.8 post-master's supervised experience in the delivery of clinical services in the treatment of
194.9 mental illness; and

194.10 (7) in licensed professional clinical counseling, the mental health professional shall be
194.11 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours
194.12 of post-master's supervised experience in the delivery of clinical services in the treatment
194.13 of mental illness.

194.14 Sec. 132. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

194.15 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
194.16 **NECESSITY.**

194.17 (a) The amount paid for a private room is 111.5 percent of the established total payment
194.18 rate for a resident if the resident is a medical assistance recipient and the private room is
194.19 considered a medical necessity for the resident or others who are affected by the resident's
194.20 condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C.
194.21 Conditions requiring a private room must be determined by the resident's attending physician
194.22 or advanced practice registered nurse and submitted to the commissioner for approval or
194.23 denial by the commissioner on the basis of medical necessity.

194.24 (b) For a nursing facility with a total property payment rate determined under section
194.25 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established
194.26 total payment rate for a resident if the resident is a medical assistance recipient and the
194.27 private room is considered a medical necessity for the resident or others who are affected
194.28 by the resident's condition. Conditions requiring a private room must be determined by the
194.29 resident's attending physician and submitted to the commissioner for approval or denial by
194.30 the commissioner on the basis of medical necessity.

195.1 Sec. 133. Minnesota Statutes 2018, section 256R.54, subdivision 1, is amended to read:

195.2 Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The
195.3 commissioner shall adopt rules under the Administrative Procedure Act to set the amount
195.4 and method of payment for ancillary materials and services provided to recipients residing
195.5 in nursing facilities. Payment for materials and services may be made to either the vendor
195.6 of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a
195.7 nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

195.8 (b) Payment for the same or similar service to a recipient shall not be made to both the
195.9 nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double
195.10 payments through audits and adjustments to the nursing facility's annual cost report as
195.11 required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements
195.12 for ancillary materials and services are cost-effective and as would be incurred by a prudent
195.13 and cost-conscious buyer.

195.14 (c) Therapy services provided to a recipient must be medically necessary and appropriate
195.15 to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician
195.16 or advanced practice registered nurse cannot provide adequate medical necessity justification,
195.17 as determined by the commissioner, the commissioner may recover or disallow the payment
195.18 for the services and may require prior authorization for therapy services as a condition of
195.19 payment or may impose administrative sanctions to limit the vendor, nursing facility, or
195.20 ordering physician's or advanced practice registered nurse's participation in the medical
195.21 assistance program. If the provider number of a nursing facility is used to bill services
195.22 provided by a vendor of therapy services that is not related to the nursing facility by
195.23 ownership, control, affiliation, or employment status, no withholding of payment shall be
195.24 imposed against the nursing facility for services not medically necessary except for funds
195.25 due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose
195.26 of this subdivision, no monetary recovery may be imposed against the nursing facility for
195.27 funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for
195.28 services not medically necessary.

195.29 (d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy
195.30 includes physical therapy, occupational therapy, speech therapy, audiology, and mental
195.31 health services that are covered services according to Minnesota Rules, parts 9505.0170 to
195.32 9505.0475.

195.33 (e) For purposes of this subdivision, "ancillary services" includes transportation defined
195.34 as a covered service in section 256B.0625, subdivision 17.

196.1 Sec. 134. Minnesota Statutes 2018, section 256R.54, subdivision 2, is amended to read:

196.2 Subd. 2. **Certification that treatment is appropriate.** The physical therapist,
196.3 occupational therapist, speech therapist, mental health professional, or audiologist who
196.4 provides or supervises the provision of therapy services, other than an initial evaluation, to
196.5 a medical assistance recipient must certify in writing that the therapy's nature, scope, duration,
196.6 and intensity are appropriate to the medical condition of the recipient every 30 days. The
196.7 therapist's statement of certification must be maintained in the recipient's medical record
196.8 together with the specific orders by the physician or advanced practice registered nurse and
196.9 the treatment plan. If the recipient's medical record does not include these documents, the
196.10 commissioner may recover or disallow the payment for such services. If the therapist
196.11 determines that the therapy's nature, scope, duration, or intensity is not appropriate to the
196.12 medical condition of the recipient, the therapist must provide a statement to that effect in
196.13 writing to the nursing facility for inclusion in the recipient's medical record. The
196.14 commissioner shall make recommendations regarding the medical necessity of services
196.15 provided.

196.16 Sec. 135. Minnesota Statutes 2018, section 257.63, subdivision 3, is amended to read:

196.17 Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered
196.18 nurse concerning the medical circumstances of the pregnancy itself and the condition and
196.19 characteristics of the child upon birth is not privileged.

196.20 Sec. 136. Minnesota Statutes 2018, section 257B.01, subdivision 3, is amended to read:

196.21 Subd. 3. **Attending physician or advanced practice registered nurse.** "Attending
196.22 physician or advanced practice registered nurse" means a physician or advanced practice
196.23 registered nurse who has primary responsibility for the treatment and care of the designator.
196.24 If physicians or advanced practice registered nurses share responsibility, another physician
196.25 or advanced practice registered nurse is acting on the attending physician's or advanced
196.26 practice registered nurse's behalf, or no physician or advanced practice registered nurse has
196.27 primary responsibility, any physician or advanced practice registered nurse who is familiar
196.28 with the designator's medical condition may act as an attending physician or advanced
196.29 practice registered nurse under this chapter.

196.30 Sec. 137. Minnesota Statutes 2018, section 257B.01, subdivision 9, is amended to read:

196.31 Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written
196.32 finding made by an attending physician or advanced practice registered nurse which states

197.1 that the designator suffers from a physically incapacitating disease or injury. No identification
197.2 of the illness in question is required.

197.3 Sec. 138. Minnesota Statutes 2018, section 257B.01, subdivision 10, is amended to read:

197.4 Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written
197.5 finding made by an attending physician or advanced practice registered nurse which states
197.6 the nature, extent, and probable duration of the designator's mental or organic incapacity.

197.7 Sec. 139. Minnesota Statutes 2018, section 257B.06, subdivision 7, is amended to read:

197.8 Subd. 7. **Restored capacity.** If a licensed physician or advanced practice registered
197.9 nurse determines that the designator has regained capacity, the co-custodian's authority that
197.10 commenced on the occurrence of a triggering event becomes inactive. Failure of a
197.11 co-custodian to immediately return the child(ren) to the designator's care entitles the
197.12 designator to an emergency hearing within five days of a request for a hearing.

197.13 Sec. 140. **REPEALER.**

197.14 Minnesota Rules, part 9505.0365, subpart 3, is repealed.

197.15

ARTICLE 5

197.16

CONTROLLED SUBSTANCES SCHEDULES

197.17 Section 1. Minnesota Statutes 2018, section 152.02, subdivision 2, is amended to read:

197.18 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

197.19 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
197.20 following substances, including their analogs, isomers, esters, ethers, salts, and salts of
197.21 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
197.22 and salts is possible:

197.23 (1) acetylmethadol;

197.24 (2) allylprodine;

197.25 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
197.26 acetate);

197.27 (4) alphameprodine;

197.28 (5) alphasubstituted methadol;

197.29 (6) alpha-methylfentanyl benzethidine;

- 198.1 (7) betacetylmethadol;
- 198.2 (8) betameprodine;
- 198.3 (9) betamethadol;
- 198.4 (10) betaprodine;
- 198.5 (11) clonitazene;
- 198.6 (12) dextromoramide;
- 198.7 (13) diampromide;
- 198.8 (14) diethylambutene;
- 198.9 (15) difenoxin;
- 198.10 (16) dimenoxadol;
- 198.11 (17) dimepheptanol;
- 198.12 (18) dimethylambutene;
- 198.13 (19) dioxaphetyl butyrate;
- 198.14 (20) dipipanone;
- 198.15 (21) ethylmethylthiambutene;
- 198.16 (22) etonitazene;
- 198.17 (23) etoxeridine;
- 198.18 (24) furethidine;
- 198.19 (25) hydroxypethidine;
- 198.20 (26) ketobemidone;
- 198.21 (27) levomoramide;
- 198.22 (28) levophenacilmorphan;
- 198.23 (29) 3-methylfentanyl;
- 198.24 (30) acetyl-alpha-methylfentanyl;
- 198.25 (31) alpha-methylthiofentanyl;
- 198.26 (32) benzylfentanyl beta-hydroxyfentanyl;
- 198.27 (33) beta-hydroxy-3-methylfentanyl;

- 199.1 (34) 3-methylthiofentanyl;
- 199.2 (35) thenylfentanyl;
- 199.3 (36) thiofentanyl;
- 199.4 (37) para-fluorofentanyl;
- 199.5 (38) morpheridine;
- 199.6 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- 199.7 (40) noracymethadol;
- 199.8 (41) norlevorphanol;
- 199.9 (42) normethadone;
- 199.10 (43) norpipanone;
- 199.11 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- 199.12 (45) phenadoxone;
- 199.13 (46) phenampromide;
- 199.14 (47) phenomorphan;
- 199.15 (48) phenoperidine;
- 199.16 (49) piritramide;
- 199.17 (50) proheptazine;
- 199.18 (51) properidine;
- 199.19 (52) propiram;
- 199.20 (53) racemoramide;
- 199.21 (54) tilidine;
- 199.22 (55) trimeperidine;
- 199.23 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);
- 199.24 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
- 199.25 methylbenzamide(U47700);
- 199.26 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);
- 199.27 ~~and~~
- 199.28 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);₂

- 200.1 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropyl
200.2 fentanyl);
- 200.3 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide (butyryl fentanyl);
- 200.4 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);
- 200.5 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
200.6 fentanyl);
- 200.7 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);
- 200.8 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);
- 200.9 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
200.10 (para-chloroisobutyryl fentanyl);
- 200.11 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
200.12 fentanyl);
- 200.13 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
200.14 (para-methoxybutyryl fentanyl);
- 200.15 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);
- 200.16 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
200.17 fentanyl or para-fluoroisobutyryl fentanyl);
- 200.18 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
200.19 acryloylfentanyl);
- 200.20 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
200.21 fentanyl);
- 200.22 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
200.23 or 2-fluorofentanyl);
- 200.24 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
200.25 (tetrahydrofuranyl fentanyl); and
- 200.26 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
200.27 esters and ethers, meaning any substance not otherwise listed under another federal
200.28 Administration Controlled Substance Code Number or not otherwise listed in this section,
200.29 and for which no exemption or approval is in effect under section 505 of the Federal Food,
200.30 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
200.31 to fentanyl by one or more of the following modifications:

- 201.1 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
201.2 or not further substituted in or on the monocycle;
- 201.3 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo,
201.4 haloalkyl, amino, or nitro groups;
- 201.5 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether,
201.6 hydroxyl, halo, haloalkyl, amino, or nitro groups;
- 201.7 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
201.8 substituted in or on the aromatic monocycle; or
- 201.9 (v) replacement of the N-propionyl group by another acyl group.
- 201.10 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
201.11 and salts of isomers, unless specifically excepted or unless listed in another schedule,
201.12 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 201.13 (1) acetorphine;
- 201.14 (2) acetyldihydrocodeine;
- 201.15 (3) benzylmorphine;
- 201.16 (4) codeine methylbromide;
- 201.17 (5) codeine-n-oxide;
- 201.18 (6) cyprenorphine;
- 201.19 (7) desomorphine;
- 201.20 (8) dihydromorphine;
- 201.21 (9) drotebanol;
- 201.22 (10) etorphine;
- 201.23 (11) heroin;
- 201.24 (12) hydromorphenol;
- 201.25 (13) methyl-desorphine;
- 201.26 (14) methyldihydromorphine;
- 201.27 (15) morphine methylbromide;
- 201.28 (16) morphine methylsulfonate;
- 201.29 (17) morphine-n-oxide;

- 202.1 (18) myrophine;
- 202.2 (19) nicocodeine;
- 202.3 (20) nicomorphine;
- 202.4 (21) normorphine;
- 202.5 (22) pholcodine; and
- 202.6 (23) thebacon.
- 202.7 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
- 202.8 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
- 202.9 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
- 202.10 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
- 202.11 possible:
- 202.12 (1) methylenedioxy amphetamine;
- 202.13 (2) methylenedioxymethamphetamine;
- 202.14 (3) methylenedioxy-N-ethylamphetamine (MDEA);
- 202.15 (4) n-hydroxy-methylenedioxyamphetamine;
- 202.16 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);
- 202.17 (6) 2,5-dimethoxyamphetamine (2,5-DMA);
- 202.18 (7) 4-methoxyamphetamine;
- 202.19 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;
- 202.20 (9) alpha-ethyltryptamine;
- 202.21 (10) bufotenine;
- 202.22 (11) diethyltryptamine;
- 202.23 (12) dimethyltryptamine;
- 202.24 (13) 3,4,5-trimethoxyamphetamine;
- 202.25 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);
- 202.26 (15) ibogaine;
- 202.27 (16) lysergic acid diethylamide (LSD);
- 202.28 (17) mescaline;

- 203.1 (18) parahexyl;
- 203.2 (19) N-ethyl-3-piperidyl benzilate;
- 203.3 (20) N-methyl-3-piperidyl benzilate;
- 203.4 (21) psilocybin;
- 203.5 (22) psilocyn;
- 203.6 (23) tenocyclidine (TPCP or TCP);
- 203.7 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- 203.8 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- 203.9 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- 203.10 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- 203.11 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- 203.12 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- 203.13 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- 203.14 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- 203.15 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- 203.16 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- 203.17 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- 203.18 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- 203.19 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- 203.20 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);
- 203.21 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
- 203.22 (2-CB-FLY);
- 203.23 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- 203.24 (40) alpha-methyltryptamine (AMT);
- 203.25 (41) N,N-diisopropyltryptamine (DiPT);
- 203.26 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);
- 203.27 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

- 204.1 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- 204.2 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- 204.3 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- 204.4 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- 204.5 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);
- 204.6 (49) 5-methoxy- α -methyltryptamine (5-MeO-AMT);
- 204.7 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- 204.8 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- 204.9 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);
- 204.10 (53) 5-methoxy- α -ethyltryptamine (5-MeO-AET);
- 204.11 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- 204.12 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- 204.13 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- 204.14 (57) methoxetamine (MXE);
- 204.15 (58) 5-iodo-2-aminoindane (5-IAI);
- 204.16 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- 204.17 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- 204.18 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- 204.19 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- 204.20 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);
- 204.21 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- 204.22 (65) N,N-Dipropyltryptamine (DPT);
- 204.23 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- 204.24 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- 204.25 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- 204.26 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

205.1 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylorketamine,
205.2 ethketamine, NENK);

205.3 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

205.4 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

205.5 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

205.6 (e) Peyote. All parts of the plant presently classified botanically as *Lophophora williamsii*
205.7 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,
205.8 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,
205.9 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
205.10 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
205.11 Church, and members of the American Indian Church are exempt from registration. Any
205.12 person who manufactures peyote for or distributes peyote to the American Indian Church,
205.13 however, is required to obtain federal registration annually and to comply with all other
205.14 requirements of law.

205.15 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
205.16 another schedule, any material compound, mixture, or preparation which contains any
205.17 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
205.18 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

205.19 (1) mecloqualone;

205.20 (2) methaqualone;

205.21 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

205.22 (4) flunitrazepam; ~~and~~

205.23 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
205.24 methoxyketamine);

205.25 (6) tianeptine;

205.26 (7) clonazepam;

205.27 (8) etizolam;

205.28 (9) flubromazolam; and

205.29 (10) flubromazepam.

205.30 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
205.31 material compound, mixture, or preparation which contains any quantity of the following

- 206.1 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
- 206.2 analogs, salts, isomers, and salts of isomers is possible:
- 206.3 (1) aminorex;
- 206.4 (2) cathinone;
- 206.5 (3) fenethylamine;
- 206.6 (4) methcathinone;
- 206.7 (5) methylaminorex;
- 206.8 (6) N,N-dimethylamphetamine;
- 206.9 (7) N-benzylpiperazine (BZP);
- 206.10 (8) methylmethcathinone (mephedrone);
- 206.11 (9) 3,4-methylenedioxy-N-methylcathinone (methydone);
- 206.12 (10) methoxymethcathinone (methedrone);
- 206.13 (11) methylenedioxypropylone (MDPV);
- 206.14 (12) 3-fluoro-N-methylcathinone (3-FMC);
- 206.15 (13) methylethcathinone (MEC);
- 206.16 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- 206.17 (15) dimethylmethcathinone (DMMC);
- 206.18 (16) fluoroamphetamine;
- 206.19 (17) fluoromethamphetamine;
- 206.20 (18) α -methylaminobutyrophenone (MABP or buphedrone);
- 206.21 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);
- 206.22 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- 206.23 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
- 206.24 naphyrone);
- 206.25 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- 206.26 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);
- 206.27 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- 206.28 (25) 4-methyl-N-ethylcathinone (4-MEC);

- 207.1 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- 207.2 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- 207.3 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);
- 207.4 (29) 4-fluoro-N-methylcathinone (4-FMC);
- 207.5 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);
- 207.6 (31) alpha-pyrrolidinobutiophenone (α -PBP);
- 207.7 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- 207.8 (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);
- 207.9 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);
- 207.10 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);
- 207.11 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);
- 207.12 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);
- 207.13 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP); ~~and~~
- 207.14 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
- 207.15 and
- 207.16 (40) any other substance, except bupropion or compounds listed under a different
- 207.17 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
- 207.18 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
- 207.19 compound is further modified in any of the following ways:
- 207.20 (i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy,
- 207.21 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
- 207.22 system by one or more other univalent substituents;
- 207.23 (ii) by substitution at the 3-position with an acyclic alkyl substituent;
- 207.24 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
- 207.25 methoxybenzyl groups; or
- 207.26 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.
- 207.27 (h) Marijuana, tetrahydrocannabinols, and synthetic cannabinoids. Unless specifically
- 207.28 excepted or unless listed in another schedule, any natural or synthetic material, compound,
- 207.29 mixture, or preparation that contains any quantity of the following substances, their analogs,

208.1 isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence
208.2 of the isomers, esters, ethers, or salts is possible:

208.3 (1) marijuana;

208.4 (2) tetrahydrocannabinols naturally contained in a plant of the genus *Cannabis*, synthetic
208.5 equivalents of the substances contained in the cannabis plant or in the resinous extractives
208.6 of the plant, or synthetic substances with similar chemical structure and pharmacological
208.7 activity to those substances contained in the plant or resinous extract, including, but not
208.8 limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4
208.9 cis or trans tetrahydrocannabinol;

208.10 (3) synthetic cannabinoids, including the following substances:

208.11 (i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole
208.12 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
208.13 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
208.14 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
208.15 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
208.16 naphthoylindoles include, but are not limited to:

208.17 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

208.18 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

208.19 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

208.20 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

208.21 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

208.22 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

208.23 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

208.24 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

208.25 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

208.26 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

208.27 (ii) Naphthylmethylindoles, which are any compounds containing a
208.28 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the
208.29 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
208.30 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further

209.1 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
209.2 ring to any extent. Examples of naphthylmethyloindoles include, but are not limited to:

209.3 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

209.4 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

209.5 (iii) Naphthoypyrroles, which are any compounds containing a 3-(1-naphthoypyrrole
209.6 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
209.7 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
209.8 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any
209.9 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
209.10 naphthoypyrroles include, but are not limited to,

209.11 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

209.12 (iv) Naphthylmethyloindenes, which are any compounds containing a naphthylideneindene
209.13 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
209.14 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
209.15 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
209.16 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
209.17 naphthylmethyloindenes include, but are not limited to,
209.18 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

209.19 (v) Phenylacetyloindoles, which are any compounds containing a 3-phenylacetyloindole
209.20 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
209.21 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
209.22 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
209.23 extent, whether or not substituted in the phenyl ring to any extent. Examples of
209.24 phenylacetyloindoles include, but are not limited to:

209.25 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

209.26 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

209.27 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

209.28 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

209.29 (vi) Cyclohexylphenols, which are compounds containing a
209.30 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
209.31 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
209.32 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted

210.1 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
210.2 limited to:

210.3 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

210.4 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol

210.5 (Cannabicyclohexanol or CP 47,497 C8 homologue);

210.6 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
210.7 -phenol (CP 55,940).

210.8 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
210.9 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
210.10 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
210.11 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
210.12 extent and whether or not substituted in the phenyl ring to any extent. Examples of
210.13 benzoylindoles include, but are not limited to:

210.14 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

210.15 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

210.16 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
210.17 48,098 or Pravadoline).

210.18 (viii) Others specifically named:

210.19 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
210.20 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

210.21 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
210.22 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

210.23 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
210.24 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

210.25 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

210.26 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
210.27 (XLR-11);

210.28 (F) 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
210.29 (AKB-48(APINACA));

210.30 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
210.31 (5-Fluoro-AKB-48);

- 211.1 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);
- 211.2 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);
- 211.3 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
- 211.4 (AB-PINACA);
- 211.5 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
- 211.6 1H-indazole-3-carboxamide (AB-FUBINACA);
- 211.7 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
- 211.8 indazole-3-carboxamide(AB-CHMINACA);
- 211.9 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate
- 211.10 (5-fluoro-AMB);
- 211.11 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);
- 211.12 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone)
- 211.13 (FUBIMINA);
- 211.14 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
- 211.15 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);
- 211.16 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
- 211.17 -1H-indole-3-carboxamide (5-fluoro-ABICA);
- 211.18 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
- 211.19 -1H-indole-3-carboxamide;
- 211.20 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
- 211.21 -1H-indazole-3-carboxamide;
- 211.22 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate;
- 211.23 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
- 211.24 H-indazole-3-carboxamide (MAB-CHMINACA);
- 211.25 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
- 211.26 (ADB-PINACA);
- 211.27 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);
- 211.28 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
- 211.29 3-carboxamide. (APP-CHMINACA);
- 211.30 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

- 212.1 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).
- 212.2 (ix) Additional substances specifically named:
- 212.3 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
- 212.4 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);
- 212.5 (B) 1-(4-cyanobutyl)-N-(2-phenylpropan-2-yl)-1 H-indazole-3-carboxamide
- 212.6 (4-CN-Cumyl-Butinaca);
- 212.7 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);
- 212.8 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1
- 212.9 H-indazole-3-carboxamide (5F-ABPINACA);
- 212.10 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
- 212.11 (MDMB CHMICA);
- 212.12 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
- 212.13 (5F-ADB; 5F-MDMB-PINACA); and
- 212.14 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
- 212.15 1H-indazole-3-carboxamide (ADB-FUBINACA).
- 212.16 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
- 212.17 for human consumption.
- 212.18 Sec. 2. Minnesota Statutes 2018, section 152.02, subdivision 3, is amended to read:
- 212.19 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.
- 212.20 (b) Unless specifically excepted or unless listed in another schedule, any of the following
- 212.21 substances whether produced directly or indirectly by extraction from substances of vegetable
- 212.22 origin or independently by means of chemical synthesis, or by a combination of extraction
- 212.23 and chemical synthesis:
- 212.24 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or
- 212.25 opiate.
- 212.26 (i) Excluding:
- 212.27 (A) apomorphine;
- 212.28 (B) thebaine-derived butorphanol;
- 212.29 (C) dextrophan;
- 212.30 (D) nalbuphine;

- 213.1 (E) nalmefene;
- 213.2 (F) naloxegol;
- 213.3 (G) naloxone;
- 213.4 (H) naltrexone; and
- 213.5 (I) their respective salts;
- 213.6 (ii) but including the following:
- 213.7 (A) opium, in all forms and extracts;
- 213.8 (B) codeine;
- 213.9 (C) dihydroetorphine;
- 213.10 (D) ethylmorphine;
- 213.11 (E) etorphine hydrochloride;
- 213.12 (F) hydrocodone;
- 213.13 (G) hydromorphone;
- 213.14 (H) metopon;
- 213.15 (I) morphine;
- 213.16 (J) oxycodone;
- 213.17 (K) oxymorphone;
- 213.18 (L) thebaine;
- 213.19 (M) oripavine;
- 213.20 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
- 213.21 or identical with any of the substances referred to in clause (1), except that these substances
- 213.22 shall not include the isoquinoline alkaloids of opium;
- 213.23 (3) opium poppy and poppy straw;
- 213.24 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
- 213.25 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
- 213.26 and derivatives), and any salt, compound, derivative, or preparation thereof which is
- 213.27 chemically equivalent or identical with any of these substances, except that the substances
- 213.28 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
- 213.29 do not contain cocaine or ecgonine;

214.1 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
214.2 or powder form which contains the phenanthrene alkaloids of the opium poppy).

214.3 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
214.4 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
214.5 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
214.6 chemical designation:

214.7 (1) alfentanil;

214.8 (2) alphaprodine;

214.9 (3) anileridine;

214.10 (4) bezitramide;

214.11 (5) bulk dextropropoxyphene (nondosage forms);

214.12 (6) carfentanil;

214.13 (7) dihydrocodeine;

214.14 (8) dihydromorphinone;

214.15 (9) diphenoxylate;

214.16 (10) fentanyl;

214.17 (11) isomethadone;

214.18 (12) levo-alpha-acetylmethadol (LAAM);

214.19 (13) levomethorphan;

214.20 (14) levorphanol;

214.21 (15) metazocine;

214.22 (16) methadone;

214.23 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

214.24 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
214.25 acid;

214.26 (19) pethidine;

214.27 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

214.28 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

- 215.1 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;
- 215.2 (23) phenazocine;
- 215.3 (24) piminodine;
- 215.4 (25) racemethorphan;
- 215.5 (26) racemorphan;
- 215.6 (27) remifentanyl;
- 215.7 (28) sufentanyl;
- 215.8 (29) tapentadol;
- 215.9 (30) ~~4-Anilino-N-phenethyl-4-piperidine (ANPP)~~ 4-Anilino-N-phenethylpiperidine.
- 215.10 (d) Unless specifically excepted or unless listed in another schedule, any material,
- 215.11 compound, mixture, or preparation which contains any quantity of the following substances
- 215.12 having a stimulant effect on the central nervous system:
- 215.13 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
- 215.14 (2) methamphetamine, its salts, isomers, and salts of its isomers;
- 215.15 (3) phenmetrazine and its salts;
- 215.16 (4) methylphenidate;
- 215.17 (5) lisdexamfetamine.
- 215.18 (e) Unless specifically excepted or unless listed in another schedule, any material,
- 215.19 compound, mixture, or preparation which contains any quantity of the following substances
- 215.20 having a depressant effect on the central nervous system, including its salts, isomers, and
- 215.21 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
- 215.22 within the specific chemical designation:
- 215.23 (1) amobarbital;
- 215.24 (2) glutethimide;
- 215.25 (3) secobarbital;
- 215.26 (4) pentobarbital;
- 215.27 (5) phencyclidine;
- 215.28 (6) phencyclidine immediate precursors:
- 215.29 (i) 1-phenylcyclohexylamine;

216.1 (ii) 1-piperidinocyclohexanecarbonitrile;

216.2 (7) phenylacetone.

216.3 (f) ~~Hallucinogenic substances~~ Cannabinoids:

216.4 (1) nabilone;

216.5 (2) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral solution

216.6 in a drug product approved for marketing by the United States Food and Drug Administration.

216.7 Sec. 3. Minnesota Statutes 2018, section 152.02, subdivision 4, is amended to read:

216.8 Subd. 4. **Schedule III.** (a) Schedule III consists of the substances listed in this subdivision.

216.9 (b) Stimulants. Unless specifically excepted or unless listed in another schedule, any
216.10 material, compound, mixture, or preparation which contains any quantity of the following
216.11 substances having a potential for abuse associated with a stimulant effect on the central
216.12 nervous system, including its salts, isomers, and salts of such isomers whenever the existence
216.13 of such salts, isomers, and salts of isomers is possible within the specific chemical
216.14 designation:

216.15 (1) benzphetamine;

216.16 (2) chlorphentermine;

216.17 (3) clortermine;

216.18 (4) phendimetrazine.

216.19 (c) Depressants. Unless specifically excepted or unless listed in another schedule, any
216.20 material, compound, mixture, or preparation which contains any quantity of the following
216.21 substances having a potential for abuse associated with a depressant effect on the central
216.22 nervous system:

216.23 (1) any compound, mixture, or preparation containing amobarbital, secobarbital,
216.24 pentobarbital or any salt thereof and one or more other active medicinal ingredients which
216.25 are not listed in any schedule;

216.26 (2) any suppository dosage form containing amobarbital, secobarbital, pentobarbital, or
216.27 any salt of any of these drugs and approved by the food and drug administration for marketing
216.28 only as a suppository;

216.29 (3) any substance which contains any quantity of a derivative of barbituric acid, or any
216.30 salt of a derivative of barbituric acid, except those substances which are specifically listed
216.31 in other schedules;

217.1 (4) any drug product containing gamma hydroxybutyric acid, including its salts, isomers,
217.2 and salts of isomers, for which an application is approved under section 505 of the federal
217.3 Food, Drug, and Cosmetic Act;

217.4 (5) any of the following substances:

217.5 (i) chlorhexadol;

217.6 (ii) ketamine, its salts, isomers and salts of isomers;

217.7 (iii) lysergic acid;

217.8 (iv) lysergic acid amide;

217.9 (v) methyprylon;

217.10 (vi) sulfondiethylmethane;

217.11 (vii) sulfonethylmethane;

217.12 (viii) sulfonmethane;

217.13 (ix) tiletamine and zolazepam and any salt thereof;

217.14 (x) embutramide;

217.15 (xi) Perampanel [2-(2-oxo-1-phenyl-5-pyridin-2-yl-1,2-Dihydropyridin-3-yl)
217.16 benzonitrile].

217.17 (d) Nalorphine.

217.18 (e) Narcotic drugs. Unless specifically excepted or unless listed in another schedule,
217.19 any material, compound, mixture, or preparation containing any of the following narcotic
217.20 drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities
217.21 as follows:

217.22 (1) not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams
217.23 per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;

217.24 (2) not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams
217.25 per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic
217.26 amounts;

217.27 (3) not more than 1.80 grams of dihydrocodeine per 100 milliliters or not more than 90
217.28 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized
217.29 therapeutic amounts;

218.1 (4) not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than
218.2 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized
218.3 therapeutic amounts;

218.4 (5) not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not
218.5 more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients
218.6 in recognized therapeutic amounts;

218.7 (6) not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with
218.8 one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

218.9 (f) Anabolic steroids, human growth hormone, and chorionic gonadotropin.

218.10 (1) Anabolic steroids, for purposes of this subdivision, means any drug or hormonal
218.11 substance, chemically and pharmacologically related to testosterone, other than estrogens,
218.12 progestins, corticosteroids, and dehydroepiandrosterone, and includes:

218.13 (i) 3[beta],17[beta]-dihydroxy-5[alpha]-androstane;

218.14 (ii) 3[alpha],17[beta]-dihydroxy-5[alpha]-androstane;

218.15 (iii) androstanedione (5[alpha]-androstan-3,17-dione);

218.16 (iv) 1-androstenediol (3[beta],17[beta]-dihydroxy-5[alpha]-androst-1-ene);

218.17 (v) 3[alpha],17[beta]-dihydroxy-5[alpha]-androst-1-ene);

218.18 (vi) 4-androstenediol (3[beta],17[beta]-dihydroxy-androst-4-ene);

218.19 (vii) 5-androstenediol (3[beta],17[beta]-dihydroxy-androst-5-ene);

218.20 (viii) 1-androstenedione (5[alpha]-androst-1-en-3,17-dione);

218.21 (ix) 4-androstenedione (androst-4-en-3,17-dione);

218.22 (x) 5-androstenedione (androst-5-en-3,17-dione);

218.23 (xi) bolasterone (7[alpha],17[alpha]-dimethyl-17[beta]-hydroxyandrost-4-en-3-one);

218.24 (xii) boldenone (17[beta]-hydroxyandrost-1,4-diene-3-one);

218.25 (xiii) boldione (androsta-1,4-diene-3,17-dione);

218.26 (xiv) calusterone (7[beta],17[alpha]-dimethyl-17[beta]-hydroxyandrost-4-en-3-one);

218.27 (xv) clostebol (4-chloro-17[beta]-hydroxyandrost-4-en-3-one);

218.28 (xvi) dehydrochloromethyltestosterone

218.29 (4-chloro-17[beta]-hydroxy-17[alpha]-methylandrost-1,4-dien-3-one);

- 219.1 (xvii) desoxymethyltestosterone (17[alpha]-methyl-5[alpha]-androst-2-en-17[beta]-ol);
- 219.2 (xviii) [delta]1-dihydrotestosterone- (17[beta]-hydroxy-5[alpha]-androst-1-en-3-one);
- 219.3 (xix) 4-dihydrotestosterone (17[beta]-hydroxy-androstan-3-one);
- 219.4 (xx) drostanolone (17[beta]hydroxy-2[alpha]-methyl-5[alpha]-androstan-3-one);
- 219.5 (xxi) ethylestrenol (17[alpha]-ethyl-17[beta]-hydroxyestr-4-ene);
- 219.6 (xxii) fluoxymesterone
- 219.7 (9-fluoro-17[alpha]-methyl-11[beta],17[beta]-dihydroxyandrost-4-en-3-one);
- 219.8 (xxiii) formebolone
- 219.9 (2-formyl-17[alpha]-methyl-11[alpha],17[beta]-dihydroxyandrost-1,4-dien-3-one);
- 219.10 (xxiv) furazabol
- 219.11 (17[alpha]-methyl-17[beta]-hydroxyandrostano[2,3-c]-furazan)13[beta]-ethyl-17[beta]
- 219.12 -hydroxygon-4-en-3-one;
- 219.13 (xxv) 4-hydroxytestosterone (4,17[beta]-dihydroxyandrost-4-en-3-one);
- 219.14 (xxvi) 4-hydroxy-19-nortestosterone (4,17[beta]-dihydroxyestr-4-en-3-one);
- 219.15 (xxvii) mestanolone (17[alpha]-methyl-17[beta]-hydroxy-5[alpha]-androstan-3-one);
- 219.16 (xxviii) mesterolone (1[alpha]-methyl-17[beta]-hydroxy-5[alpha]-androstan-3-one);
- 219.17 (xxix) methandienone (17[alpha]-methyl-17[beta]-hydroxyandrost-1,4-dien-3-one);
- 219.18 (xxx) methandriol (17[alpha]-methyl-3[beta],17[beta]-dihydroxyandrost-5-ene);
- 219.19 (xxxii) methasterone (2 alpha-17 alpha-dimethyl-5 alpha-androstan-17beta-ol-3-one);
- 219.20 (xxxiii) methenolone (1-methyl-17[beta]-hydroxy-5[alpha]-androst-1-en-3-one);
- 219.21 (xxxiv) 17[alpha]-methyl-3[beta],17[beta]-dihydroxy-5[alpha]-androstane;
- 219.22 (xxxv) 17[alpha]-methyl-3[alpha],17[beta]-dihydroxy-5[alpha]-androstane;
- 219.23 (xxxvi) 17[alpha]-methyl-3[beta],17[beta]-dihydroxyandrost-4-ene;
- 219.24 (xxxvii) 17[alpha]-methyl-4-hydroxynandrolone
- 219.25 (17[alpha]-methyl-4-hydroxy-17[beta]-hydroxyestr-4-en-3-one);
- 219.26 (xxxviii) methyldienolone (17[alpha]-methyl-17[beta]-hydroxyestra-4,9(10)-dien-3-one);
- 219.27 (xxxix) methyltrienolone (17[alpha]-methyl-17[beta]-hydroxyestra-4,9-11-trien-3-one);
- 219.28 (xl) methyltestosterone (17[alpha]-methyl-17[beta]-hydroxyandrost-4-en-3-one);

- 220.1 (xl) mibolerone (7[alpha],17[alpha]-dimethyl-17[beta]-hydroxyestr-4-en-3-one);
- 220.2 (xli) 17[alpha]-methyl-[delta]1-dihydrotestosterone
- 220.3 (17[beta]-hydroxy-17[alpha]-methyl-5[alpha]-androst-1-en-3-one);
- 220.4 (xlii) nandrolone (17[beta]-hydroxyestr-4-en-3-one);
- 220.5 (xliii) 19-nor-4-androstenediol (3[beta],17[beta]-dihydroxyestr-4-ene;
- 220.6 (xliv) 3[alpha],17[beta]-dihydroxyestr-4-ene); 19-nor-5-androstenediol
- 220.7 (3[beta],17[beta]-dihydroxyestr-5-ene;
- 220.8 (xlv) 3[alpha],17[beta]-dihydroxyestr-5-ene);
- 220.9 (xlvi) 19-nor-4,9(10)-androstadienedione (estra-4,9(10)-diene-3,17-dione);
- 220.10 (xlvii) 19-nor-5-androstenedione (estr-5-en-3,17-dione);
- 220.11 (xlviii) norbolethone (13[beta],17[alpha]-diethyl-17[beta]-hydroxygon-4-en-3-one);
- 220.12 (xlix) norclostebol (4-chloro-17[beta]-hydroxyestr-4-en-3-one);
- 220.13 (l) norethandrolone (17[alpha]-ethyl-17[beta]-hydroxyestr-4-en-3-one);
- 220.14 (li) normethandrolone (17[alpha]-methyl-17[beta]-hydroxyestr-4-en-3-one);
- 220.15 (lii) oxandrolone (17[alpha]-methyl-17[beta]-hydroxy-2-oxa-5[alpha]-androstan-3-one);
- 220.16 (liii) oxymesterone (17[alpha]-methyl-4,17[beta]-dihydroxyandrost-4-en-3-one);
- 220.17 (liv) oxymetholone
- 220.18 (17[alpha]-methyl-2-hydroxymethylene-17[beta]-hydroxy-5[alpha]-androstan-3-one);
- 220.19 (lv) prostanazol (17 beta-hydroxy-5 alpha-androstano[3,2-C]pyrazole;
- 220.20 (lvi) stanozolol
- 220.21 (17[alpha]-methyl-17[beta]-hydroxy-5[alpha]-androst-2-eno[3,2-c]-pyrazole);
- 220.22 (lvii) stenbolone (17[beta]-hydroxy-2-methyl-5[alpha]-androst-1-en-3-one);
- 220.23 (lviii) testolactone (13-hydroxy-3-oxo-13,17-secoandrosta-1,4-dien-17-oic acid lactone);
- 220.24 (lix) testosterone (17[beta]-hydroxyandrost-4-en-3-one);
- 220.25 (lx) tetrahydrogestrinone
- 220.26 (13[beta],17[alpha]-diethyl-17[beta]-hydroxygon-4,9,11-trien-3-one);
- 220.27 (lxi) trenbolone (17[beta]-hydroxyestr-4,9,11-trien-3-one);
- 220.28 (lxii) any salt, ester, or ether of a drug or substance described in this paragraph.

- 221.1 Anabolic steroids are not included if they are: (A) expressly intended for administration
221.2 through implants to cattle or other nonhuman species; and (B) approved by the United States
221.3 Food and Drug Administration for that use;
- 221.4 (2) Human growth hormones.
- 221.5 (3) Chorionic gonadotropin, except that a product containing chorionic gonadotropin is
221.6 not included if it is:
- 221.7 (i) expressly intended for administration to cattle or other nonhuman species; and
221.8 (ii) approved by the United States Food and Drug Administration for that use.
- 221.9 (g) Hallucinogenic substances. Dronabinol (synthetic) in sesame oil and encapsulated
221.10 in a soft gelatin capsule in a United States Food and Drug Administration approved product.
- 221.11 (h) Any material, compound, mixture, or preparation containing the following narcotic
221.12 drug or its salt: buprenorphine.

62U.15 ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.

Subd. 2. **Learning collaborative.** By July 1, 2012, the commissioner shall develop a health care home learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients under section 256B.0751, subdivision 5, for providers, clinics, care coordinators, clinic administrators, patient partners and families, and community resources including public health.

144.121 X-RAY MACHINES; OTHER SOURCES OF IONIZING RADIATION.

Subd. 3. **Exemption.** Notwithstanding rules adopted by the commissioner under section 144.12, subdivision 1, clause (15), practitioners of veterinary medicine are not required to conduct densitometry and sensitometry tests as part of any ionizing radiation quality assurance program.

Subd. 5b. **Variance of scope of practice.** The commissioner may grant a variance according to Minnesota Rules, parts 4717.7000 to 4717.7050, to a facility for the scope of practice of an x-ray operator in cases where the delivery of health care would otherwise be compromised if a variance were not granted. The request for a variance must be in writing, state the circumstances that constitute hardship, state the period of time the facility wishes to have the variance for the scope of practice in place, and state the alternative measures that will be taken if the variance is granted. The commissioner shall set forth in writing the reasons for granting or denying the variance. Variances granted by the commissioner must specify in writing the time limitation and required alternative measures to be taken by the facility. A request for the variance shall be denied if the commissioner finds the circumstances stated by the facility do not support a claim of hardship, the requested time period for the variance is unreasonable, the alternative measures proposed by the facility are not equivalent to the scope of practice, or the request for the variance is not submitted to the commissioner in a timely manner.

147A.01 DEFINITIONS.

Subd. 4. **Agreement.** "Agreement" means the document described in section 147A.20.

Subd. 11. **Drug category.** "Drug category" means one of the categories listed on the physician-physician assistant delegation agreement.

Subd. 16a. **Notice of intent to practice.** "Notice of intent to practice" means a document sent to the board by a licensed physician assistant that documents the adoption of a physician-physician assistant delegation agreement and provides the names, addresses, and information required by section 147A.20.

Subd. 17a. **Physician-physician assistant delegation agreement.** "Physician-physician assistant delegation agreement" means the document prepared and signed by the physician and physician assistant affirming the supervisory relationship and defining the physician assistant scope of practice. The physician-physician assistant delegation agreement outlines the role of the physician assistant in the practice, describes the means of supervision, and specifies the categories of drugs, controlled substances, and medical devices that the supervising physician delegates to the physician assistant to prescribe. The physician-physician assistant delegation agreement must comply with the requirements of section 147A.20, be kept on file at the address of record, and be made available to the board or its representative upon request.

Subd. 24. **Supervision.** "Supervision" means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant delegation agreement.

Subd. 25. **Temporary license.** "Temporary license" means a license granted to a physician assistant who meets all of the qualifications for licensure but has not yet been approved for licensure at a meeting of the board.

147A.04 TEMPORARY LICENSE.

The board may issue a temporary license to practice to a physician assistant eligible for licensure under this chapter only if the application for licensure is complete, all requirements have been met, and a nonrefundable fee set by the board has been paid. The temporary license remains valid only until the next meeting of the board at which a decision is made on the application for licensure.

147A.10 SATELLITE SETTINGS.

Physician assistants may render services in a setting geographically remote from the supervising physician.

147A.11 EXCLUSIONS OF LIMITATIONS ON EMPLOYMENT.

Nothing in this chapter shall be construed to limit the employment arrangement of a physician assistant licensed under this chapter.

147A.18 DELEGATED AUTHORITY TO PRESCRIBE, DISPENSE, AND ADMINISTER DRUGS AND MEDICAL DEVICES.

Subdivision 1. **Delegation.** (a) A supervising physician may delegate to a physician assistant who is licensed by the board, certified by the National Commission on Certification of Physician Assistants or successor agency approved by the board, and who is under the supervising physician's supervision, the authority to prescribe, dispense, and administer legend drugs, controlled substances, and medical devices subject to the requirements in this section. The authority to dispense includes, but is not limited to, the authority to request, receive, and dispense sample drugs. This authority to dispense extends only to those drugs described in the written agreement developed under paragraph (b).

(b) The delegation agreement between the physician assistant and supervising physician must include a statement by the supervising physician regarding delegation or nondelegation of the functions of prescribing, dispensing, and administering legend drugs, controlled substances, and medical devices to the physician assistant. The statement must include categories of drugs for which the supervising physician delegates prescriptive and dispensing authority, including controlled substances when applicable. The delegation must be appropriate to the physician assistant's practice and within the scope of the physician assistant's training. Physician assistants who have been delegated the authority to prescribe, dispense, and administer legend drugs, controlled substances, and medical devices shall provide evidence of current certification by the National Commission on Certification of Physician Assistants or its successor agency when applying for licensure or license renewal as physician assistants. Physician assistants who have been delegated the authority to prescribe controlled substances must also hold a valid DEA registration. Supervising physicians shall retrospectively review the prescribing, dispensing, and administering of legend drugs, controlled substances, and medical devices by physician assistants, when this authority has been delegated to the physician assistant as part of the physician-physician assistant delegation agreement. The process and schedule for the review must be outlined in the physician-physician assistant delegation agreement.

(c) The board may establish by rule:

(1) a system of identifying physician assistants eligible to prescribe, administer, and dispense legend drugs and medical devices;

(2) a system of identifying physician assistants eligible to prescribe, administer, and dispense controlled substances;

(3) a method of determining the categories of legend drugs, controlled substances, and medical devices that each physician assistant is allowed to prescribe, administer, and dispense; and

(4) a system of transmitting to pharmacies a listing of physician assistants eligible to prescribe legend drugs, controlled substances, and medical devices.

Subd. 2. **Termination and reinstatement of prescribing authority.** The authority of a physician assistant to prescribe, dispense, and administer legend drugs, controlled substances, and medical devices shall end immediately when:

(1) the physician-physician assistant delegation agreement is terminated;

(2) the authority to prescribe, dispense, and administer is terminated or withdrawn by the supervising physician;

(3) the physician assistant's license is placed on inactive status;

(4) the physician assistant loses National Commission on Certification of Physician Assistants or successor agency certification; or

(5) the physician assistant loses or terminates licensure status.

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 conform with the agreement, chapter 151, and this chapter.

147A.20 PHYSICIAN-PHYSICIAN ASSISTANT AGREEMENT DOCUMENTS.

Subdivision 1. **Physician-physician assistant delegation agreement.** (a) A physician assistant and supervising physician must sign a physician-physician assistant delegation agreement which specifies scope of practice and manner of supervision as required by the board. The agreement must contain:

- (1) a description of the practice setting;
- (2) a listing of categories of delegated duties;
- (3) a description of supervision type; and
- (4) a description of the process and schedule for review of prescribing, dispensing, and administering legend and controlled drugs and medical devices by the physician assistant authorized to prescribe.

(b) The agreement must be maintained by the supervising physician and physician assistant and made available to the board upon request. If there is a delegation of prescribing, administering, and dispensing of legend drugs, controlled substances, and medical devices, the agreement shall include a description of the prescriptive authority delegated to the physician assistant. Physician assistants shall have a separate agreement for each place of employment. Agreements must be reviewed and updated on an annual basis. The supervising physician and physician assistant must maintain the physician-physician assistant delegation agreement at the address of record.

(c) Physician assistants must provide written notification to the board within 30 days of the following:

- (1) name change;
- (2) address of record change; and
- (3) telephone number of record change.

Subd. 2. **Practice location notification.** A licensed physician assistant shall submit a practice location notification to the board within 30 business days of starting practice, changing practice location, or changing supervising physician. The notification shall include the name, business address, and telephone number of the supervising physician and the physician assistant. Individuals who practice without submitting a practice location notification shall be subject to disciplinary action under section 147A.13 for practicing without a license, unless the care is provided in response to a disaster or emergency situation pursuant to section 147A.23.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable household income is above 275 percent of the federal poverty guidelines for the same household size but less than or equal to 280 percent of the federal poverty guidelines for the same household size or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act.

256B.0752 HEALTH CARE HOME REPORTING REQUIREMENTS.

Subdivision 1. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care

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home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors beginning December 15, 2009, and each December 15 thereafter.

Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

(1) the number of state health care program enrollees in health care homes and the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language;

(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees;

(6) the estimated impact of health care homes on health disparities; and

(7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

256L.04 ELIGIBLE PERSONS.

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

7380.0280 SUPPLEMENTAL ASSISTANCE FOR DISADVANTAGED COMMUNITIES.

Subpart 1. **In general.** The authority shall provide supplemental assistance, in the form of a reduction in the amount of loan principal which a borrower has to repay, to public water supply systems owned by a governmental or intergovernmental agency, a nonprofit organization, an Indian tribe, or any combination of them that meet the criteria in subpart 2. The total amount of supplemental assistance provided in any one year shall not exceed ten percent of the federal capitalization grants available.

Subp. 2. **Disadvantaged community criteria.** An applicant is eligible for supplemental assistance as described in subpart 1 if:

A. the applicant's project receives public health priority points on the Department of Health's project priority list under part 4720.9020; and

B. after completion of the project, the applicant will have an estimated average annual residential water system cost of 1.4 percent of median household income or more.

Subp. 3. **Amount of supplemental assistance.** The supplemental assistance amount shall be equal to 80 percent of the amount needed to reduce the as-bid average annual residential water system cost to 1.4 percent of median household income. If the current average annual residential water system cost is at or exceeds 1.4 percent of median household income, the supplemental assistance amount shall be 80 percent of the project cost. The supplemental assistance amount provided to a single borrower shall not exceed \$500,000.

9505.0365 PROSTHETIC AND ORTHOTIC DEVICES.

Subp. 3. **Payment limitation; ambulatory aid.** To be eligible for medical assistance payment, an ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedics or physiatrics or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

Prior authorization of an ambulatory aid is required for an aid that costs in excess of the limits specified in the provider's performance agreement.