SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 1966

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DATE	D-PG	OFFICIAL STATUS
03/04/2019	626	Introduction and first reading Referred to Health and Human Services Finance and Policy
02/27/2020		Comm report: To pass as amended Second reading

1.1 A bill for an act

1.2 relating to health; adding advanced practice registered nurses to certain statutes;
1.3 amending Minnesota Statutes 2018, sections 62D.09, subdivision 1; 62E.06,
1.4 subdivision 1; 62J.17, subdivision 4a; 62J.495, subdivision 1a; 62J.52, subdivision
1.5 2; 62J.823, subdivision 3; 62Q.43, subdivisions 1, 2; 62Q.54; 62Q.57, subdivision
1.6 1; 62Q.73, subdivision 7; 62Q.733, subdivision 3; 62Q.74, subdivision 1; 62S.08,
1.7 subdivision 3; 62S.20, subdivision 5b; 62S.21, subdivision 2; 62S.268, subdivision
1.8 1; 144.3345, subdivision 1; 144.3352; 144.34; 144.441, subdivisions 4, 5; 144.442,
1.9 subdivision 1; 144.4803, subdivisions 1, 4, 10, by adding a subdivision; 144.4806;
1.10 144.4807, subdivisions 1, 2, 4; 144.50, subdivision 2; 144.55, subdivision 6;
1.11 144.6501, subdivision 7; 144.651, subdivisions 7, 8, 9, 10, 12, 14, 31, 33; 144.652,
1.12 subdivision 2; 144.69; 144.7402, subdivision 2; 144.7406, subdivision 2; 144.7407,
1.13 subdivision 2; 144.7414, subdivision 2; 144.7415, subdivision 2; 144.9502,
1.14 subdivision 4; 144.966, subdivisions 3, 6; 144A.135; 144A.161, subdivisions 5,
1.15 5a, 5e, 5g; 144A.75, subdivisions 3, 6; 144A.752, subdivision 1; 145.853,
1.16 subdivision 5; 145.892, subdivision 3; 145.94, subdivision 2; 145B.13; 145C.02;
1.17 145C.06; 145C.07, subdivision 1; 145C.16; 148.6438, subdivision 1; 151.19,
1.18 subdivision 4; 151.21, subdivision 4a; 152.32, subdivision 3; 245A.143, subdivision
1.19 8; 245A.1435; 245C.02, subdivision 18; 245C.04, subdivision 1; 245D.02,
1.20 subdivision 11; 245D.11, subdivision 2; 245D.22, subdivision 7; 245D.25,
1.21 subdivision 2; 245G.08, subdivisions 2, 5; 245G.21, subdivisions 2, 3; 246.711,
1.22 subdivision 2; 246.715, subdivision 2; 246.716, subdivision 2; 246.721; 246.722;
1.23 251.043, subdivision 1; 252A.02, subdivision 12; 252A.04, subdivision 2; 252A.20,
1.24 subdivision 1; 253B.03, subdivisions 4, 6d; 253B.06, subdivisions 1, 2; 253B.07,
1.25 subdivision 2; 253B.08, subdivision 5; 253B.092, subdivisions 2, 3, 6, 8;
1.26 253B.0921; 253B.20, subdivisions 4, 6; 253B.23, subdivision 4; 254A.08,
1.27 subdivision 2; 256.9685, subdivision 1c; 256.975, subdivisions 7a, 11; 256B.04,
1.28 subdivision 14a; 256B.043, subdivision 2; 256B.055, subdivision 12; 256B.0622,
1.29 subdivision 2b; 256B.0623, subdivision 2; 256B.0625, subdivisions 12, 26, 28;
1.30 256B.0654, subdivisions 1, 2a, 3, 4; 256B.0659, subdivisions 2, 4, 8; 256B.73,
1.31 subdivision 5; 256J.08, subdivision 73a; 256R.54, subdivisions 1, 2; 257.63,
1.32 subdivision 3; 257B.01, subdivisions 3, 9, 10; 257B.06, subdivision 7; Minnesota
1.33 Statutes 2019 Supplement, sections 62J.23, subdivision 2; 62Q.184, subdivision
1.34 1; 144.55, subdivision 2; 145C.05, subdivision 2; 245G.08, subdivision 3; 245H.11;
1.35 256B.0625, subdivisions 13, 17, 60a; 256B.0659, subdivision 11; 256B.0913,
1.36 subdivision 8; 256R.44; repealing Minnesota Rules, part 9505.0365, subpart 3.

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

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

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

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

2.14 (1) health care services not provided;

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

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

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

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

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

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

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

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

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

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

(1) hospital services;

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

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

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

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

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

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

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

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

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

4.7 (13) services of a physical therapist;

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

4.11 (15) services of an occupational therapist.

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

4.14 (1) any charge for care for injury or disease either (i) arising out of an injury in the course
4.15 of employment and subject to a workers' compensation or similar law, (ii) for which benefits
4.16 are payable without regard to fault under coverage statutorily required to be contained in
4.17 any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii)
4.18 for which benefits are payable under another policy of accident and health insurance,
4.19 Medicare, or any other governmental program except as otherwise provided by section
4.20 62A.04, subdivision 3, clause (4);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.6 (2) a pharmaceutical manufacturer, medical supply or device manufacturer, health plan
7.7 company, or pharmacy benefit manager providing to a patient, at a discount or reduced
7.8 price or free of charge, ancillary products necessary for treatment of the medical condition
7.9 for which the prescription drug, medical supply, or medical equipment was prescribed or
7.10 provided; and

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

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

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

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

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

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

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

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

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

8.8 (1) provide clinical decision support;

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

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

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

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

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

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

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

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

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

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

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

9.12 (2) at least one of the following:

9.13 (i) the specific diagnostic-related group code;

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

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

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

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

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

9.22 (b) "Clinical practice guideline" means a systematically developed statement to assist
9.23 health care providers and enrollees in making decisions about appropriate health care services
9.24 for specific clinical circumstances and conditions developed independently of a health plan
9.25 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical
9.26 practice guideline also includes a preferred drug list developed in accordance with section
9.27 256B.0625.

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

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

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

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

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

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

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

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

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

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

If an enrollee is a resident of a health care facility licensed under chapter 144A or a housing with services establishment registered under chapter 144D, the enrollee's primary care ~~physician~~ provider must refer the enrollee to that facility's skilled nursing unit or that

11.1 facility's appropriate care setting, provided that the health plan company and the provider
11.2 can best meet the patient's needs in that setting, if the following conditions are met:

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

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

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

11.10 Subdivision 1. **Choice of primary care provider.** (a) If a health plan company offering
11.11 a group health plan, or an individual health plan that is not a grandfathered plan, requires
11.12 or provides for the designation by an enrollee of a participating primary care provider, the
11.13 health plan company shall permit each enrollee to:

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

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

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

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

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

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

11.30 (c) For an external review of any issue in an adverse determination by a health plan
11.31 company, other than a health plan company licensed under chapter 62D, that requires a

12.1 medical necessity determination, the external review must determine whether the adverse
12.2 determination was consistent with the definition of medically necessary care in section
12.3 62Q.53, subdivision 2.

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

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

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

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

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

12.19 (1) health;

12.20 (2) no-fault automobile medical benefits; or

12.21 (3) workers' compensation medical benefits.

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

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

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

12.28 COMPANY NAME

12.29 ADDRESS - CITY AND STATE

12.30 TELEPHONE NUMBER

12.31 LONG-TERM CARE INSURANCE

13.1 OUTLINE OF COVERAGE

13.2 Policy Number or Group Master Policy and Certificate Number

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

13.6 CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based
13.7 upon your responses to the questions on your application. A copy of your (application)
13.8 (enrollment form) (is enclosed) (was retained by you when you applied). If your answers
13.9 are incorrect or untrue, the company has the right to deny benefits or rescind your policy.
13.10 The best time to clear up any questions is now, before a claim arises. If, for any reason, any
13.11 of your answers are incorrect, contact the company at this address: (insert address).

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

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

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

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

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

13.29 (1) (Policies and certificates that are guaranteed renewable shall contain the following
13.30 statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED
13.31 RENEWABLE. This means you have the right, subject to the terms of your policy,
13.32 (certificate) to continue this policy as long as you pay your premiums on time. (Company

14.1 name) cannot change any of the terms of your policy on its own, except that, in the future,
14.2 IT MAY INCREASE THE PREMIUM YOU PAY.

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

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

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

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

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

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

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

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

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

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

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

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

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

15.9 (9) BENEFITS PROVIDED BY THIS POLICY.

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

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

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

15.14 (d) (Eligibility for payment of benefits.)

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

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

15.23 (10) LIMITATIONS AND EXCLUSIONS:

15.24 Describe:

15.25 (a) preexisting conditions;

15.26 (b) noneligible facilities/provider;

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

15.29 (d) exclusions/exceptions; and

15.30 (e) limitations.

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

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

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

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

16.10 (b) any automatic benefit adjustment provisions;

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

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

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

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

16.24 (13) PREMIUM.

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

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

16.28 (14) ADDITIONAL FEATURES.

16.29 (a) Indicate if medical underwriting is used.

16.30 (b) Describe other important features.

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

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

17.7 Subd. 5b. **Benefit triggers.** Activities of daily living and cognitive impairment must be
17.8 used to measure an insured's need for long-term care and must be described in the policy
17.9 or certificate in a separate paragraph and must be labeled "Eligibility for the Payment of
17.10 Benefits." Any additional benefit triggers must also be explained in this section. If these
17.11 triggers differ for different benefits, explanation of the trigger must accompany each benefit
17.12 description. If an attending physician, advanced practice registered nurse, or other specified
17.13 person must certify a certain level of functional dependency in order to be eligible for
17.14 benefits, this too shall be specified.

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

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

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

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

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

17.31 (b) "Chronically ill individual" has the meaning prescribed for this term by section
17.32 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a

18.1 chronically ill individual means any individual who has been certified by a licensed health
18.2 care practitioner as being unable to perform, without substantial assistance from another
18.3 individual, at least two activities of daily living for a period of at least 90 days due to a loss
18.4 of functional capacity, or requiring substantial supervision to protect the individual from
18.5 threats to health and safety due to severe cognitive impairment.

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

18.9 (c) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1)
18.10 of the Social Security Act, an advanced practice registered nurse, a registered professional
18.11 nurse, licensed social worker, or other individual who meets requirements prescribed by
18.12 the Secretary of the Treasury.

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

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

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

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

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

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

18.27 (2) hospitals eligible for rural hospital capital improvement grants, as defined in section
18.28 144.148;

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

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

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

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

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

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

19.8 **144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT**
19.9 **IMMUNIZATION.**

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

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

19.14 **144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.**

19.15 Any physician or advanced practice registered nurse having under professional care any
19.16 person whom the physician or advanced practice registered nurse believes to be suffering
19.17 from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas,
19.18 wood alcohol, or mercury, or their compounds, or from anthrax or from compressed-air
19.19 illness or any other disease contracted as a result of the nature of the employment of such
19.20 person shall within five days mail to the Department of Health a report stating the name,
19.21 address, and occupation of such patient, the name, address, and business of the patient's
19.22 employer, the nature of the disease, and such other information as may reasonably be required
19.23 by the department. The department shall prepare and furnish the physicians and advanced
19.24 practice registered nurses of this state suitable blanks for the reports herein required. No
19.25 report made pursuant to the provisions of this section shall be admissible as evidence of the
19.26 facts therein stated in any action at law or in any action under the Workers' Compensation
19.27 Act against any employer of such diseased person. The Department of Health is authorized
19.28 to investigate and to make recommendations for the elimination or prevention of occupational
19.29 diseases which have been reported to it, or which shall be reported to it, in accordance with
19.30 the provisions of this section. The department is also authorized to study and provide advice
19.31 in regard to conditions that may be suspected of causing occupational diseases. Information
19.32 obtained upon investigations made in accordance with the provisions of this section shall
19.33 not be admissible as evidence in any action at law to recover damages for personal injury

20.1 or in any action under the Workers' Compensation Act. Nothing herein contained shall be
20.2 construed to interfere with or limit the powers of the Department of Labor and Industry to
20.3 make inspections of places of employment or issue orders for the protection of the health
20.4 of the persons therein employed. When upon investigation the commissioner of health
20.5 reaches a conclusion that a condition exists which is dangerous to the life and health of the
20.6 workers in any industry or factory or other industrial institutions the commissioner shall
20.7 file a report thereon with the Department of Labor and Industry.

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

20.9 Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision
20.10 2, a person employed by the designated school or school district shall submit to the
20.11 administrator or other person having general control and supervision of the school one of
20.12 the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

21.23 (3) the manner by which tuberculosis is transmitted;

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

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

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

21.27 (7) that screening has been scheduled; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23.25 **144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27.2 Subd. 8. **Relationship with other health services.** Patients and residents who receive
27.3 services from an outside provider are entitled, upon request, to be told the identity of the
27.4 provider. Residents shall be informed, in writing, of any health care services which are
27.5 provided to those residents by individuals, corporations, or organizations other than their
27.6 facility. Information shall include the name of the outside provider, the address, and a
27.7 description of the service which may be rendered. In cases where it is medically inadvisable,
27.8 as documented by the attending physician or advanced practice registered nurse in a patient's
27.9 or resident's care record, the information shall be given to the patient's or resident's guardian
27.10 or other person designated by the patient or resident as a representative.

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

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

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

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

27.30 Subd. 10. **Participation in planning treatment; notification of family members.** (a)
27.31 Patients and residents shall have the right to participate in the planning of their health care.
27.32 This right includes the opportunity to discuss treatment and alternatives with individual
27.33 caregivers, the opportunity to request and participate in formal care conferences, and the

28.1 right to include a family member or other chosen representative, or both. In the event that
28.2 the patient or resident cannot be present, a family member or other representative chosen
28.3 by the patient or resident may be included in such conferences. A chosen representative
28.4 may include a doula of the patient's choice.

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

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

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

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

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

28.32 (c) In making reasonable efforts to notify a family member or designated emergency
28.33 contact, the facility shall attempt to identify family members or a designated emergency
28.34 contact by examining the personal effects of the patient or resident and the medical records

of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

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

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

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

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

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

Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical

30.1 restraint and isolation except in emergency situations involving a likelihood that the patient
30.2 will physically harm the patient's self or others. These procedures may not be used for
30.3 disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation
30.4 or restraint may be used only upon the prior authorization of a physician, advanced practice
30.5 registered nurse, psychiatrist, or licensed psychologist, only when less restrictive measures
30.6 are ineffective or not feasible and only for the shortest time necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31.6 (f) When determining nursing facility compliance with state and federal standards for
31.7 the use of physical restraints, the commissioner of health is bound by the statements and
31.8 determinations contained in the attending physician's or advanced practice registered nurse's
31.9 order regarding medical symptoms. For purposes of this order, "medical symptoms" include
31.10 the request by a competent resident, family member of a resident who is not competent, or
31.11 legally appointed conservator, guardian, or health care agent as defined under section
31.12 145C.01, that the facility provide a physical restraint in order to enhance the physical safety
31.13 of the resident.

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

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

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

31.27 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

31.28 Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data
31.29 collected on individuals by the cancer surveillance system, including the names and personal
31.30 identifiers of persons required in section 144.68 to report, shall be private and may only be
31.31 used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68.
31.32 Any disclosure other than is provided for in this section and sections 144.671, 144.672, and
31.33 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by

32.1 rule, and as part of an epidemiologic investigation, an officer or employee of the
32.2 commissioner of health may interview patients named in any such report, or relatives of
32.3 any such patient, only after the consent of the attending physician, advanced practice
32.4 registered nurse, or surgeon is obtained.

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

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

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

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

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

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

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

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

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

33.1 medical treatment for the emergency medical services person under section 144.7414,
33.2 subdivision 2;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.3 (2) a process for an infectious disease specialist, or a licensed physician or advanced
35.4 practice registered nurse who is knowledgeable about the most current recommendations
35.5 of the United States Public Health Service in consultation with an infectious disease specialist,
35.6 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
35.7 occurred and (ii) to provide, under the direction of a licensed physician or advanced practice
35.8 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
35.9 to the particular blood-borne pathogen or pathogens for which a significant exposure has
35.10 been determined;

35.11 (3) if there has been a significant exposure, a process to determine whether the source
35.12 individual has a blood-borne pathogen through disclosure of test results, or through blood
35.13 collection and testing as required by sections 144.7401 to 144.7415;

35.14 (4) a process for providing appropriate counseling prior to and following testing for a
35.15 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
35.16 follow-up recommendations according to the most current recommendations of the United
35.17 States Public Health Service, recommendations for testing, and treatment to the emergency
35.18 medical services person;

35.19 (5) a process for providing appropriate counseling under clause (4) to the emergency
35.20 medical services person and the source individual; and

35.21 (6) compliance with applicable state and federal laws relating to data practices,
35.22 confidentiality, informed consent, and the patient bill of rights.

35.23 Sec. 52. Minnesota Statutes 2018, section 144.7415, subdivision 2, is amended to read:

35.24 Subd. 2. **Immunity.** A facility, licensed physician, advanced practice registered nurse,
35.25 and designated health care personnel are immune from liability in any civil, administrative,
35.26 or criminal action relating to the disclosure of test results to an emergency medical services
35.27 person or emergency medical services agency and the testing of a blood sample from the
35.28 source individual for blood-borne pathogens if a good faith effort has been made to comply
35.29 with sections 144.7401 to 144.7415.

35.30 Sec. 53. Minnesota Statutes 2018, section 144.9502, subdivision 4, is amended to read:

35.31 Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis
35.32 reports required in this section must specify:

36.1 (1) whether the specimen was collected as a capillary or venous sample;

36.2 (2) the date the sample was collected;

36.3 (3) the results of the blood lead analysis;

36.4 (4) the date the sample was analyzed;

36.5 (5) the method of analysis used;

36.6 (6) the full name, address, and phone number of the laboratory performing the analysis;

36.7 (7) the full name, address, and phone number of the physician, advanced practice
36.8 registered nurse, or facility requesting the analysis;

36.9 (8) the full name, address, and phone number of the person with the blood lead level,
36.10 and the person's birthdate, gender, and race.

36.11 Sec. 54. Minnesota Statutes 2018, section 144.966, subdivision 3, is amended to read:

36.12 Subd. 3. **Early hearing detection and intervention programs.** All hospitals shall
36.13 establish an early hearing detection and intervention (EHDI) program. Each EHDI program
36.14 shall:

36.15 (1) in advance of any hearing screening testing, provide to the newborn's or infant's
36.16 parents or parent information concerning the nature of the screening procedure, applicable
36.17 costs of the screening procedure, the potential risks and effects of hearing loss, and the
36.18 benefits of early detection and intervention;

36.19 (2) comply with parental election as described under section 144.125, subdivision 4;

36.20 (3) develop policies and procedures for screening and rescreening based on Department
36.21 of Health recommendations;

36.22 (4) provide appropriate training and monitoring of individuals responsible for performing
36.23 hearing screening tests as recommended by the Department of Health;

36.24 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain
36.25 in the hospital for a prolonged period, testing shall be performed prior to three months of
36.26 age or when medically feasible;

36.27 (6) develop and implement procedures for documenting the results of all hearing screening
36.28 tests;

36.29 (7) inform the newborn's or infant's parents or parent, primary care physician or advanced
36.30 practice registered nurse, and the Department of Health according to recommendations of

37.1 the Department of Health of the results of the hearing screening test or rescreening if
37.2 conducted, or if the newborn or infant was not successfully tested. The hospital that
37.3 discharges the newborn or infant to home is responsible for the screening; and

37.4 (8) collect performance data specified by the Department of Health.

37.5 Sec. 55. Minnesota Statutes 2018, section 144.966, subdivision 6, is amended to read:

37.6 Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician, advanced
37.7 practice registered nurse, or hospital shall be civilly or criminally liable for failure to conduct
37.8 hearing screening testing.

37.9 (b) No physician, midwife, nurse, other health professional, or hospital acting in
37.10 compliance with this section shall be civilly or criminally liable for any acts conforming
37.11 with this section, including furnishing information required according to this section.

37.12 Sec. 56. Minnesota Statutes 2018, section 144A.135, is amended to read:

37.13 **144A.135 TRANSFER AND DISCHARGE APPEALS.**

37.14 (a) The commissioner shall establish a mechanism for hearing appeals on transfers and
37.15 discharges of residents by nursing homes or boarding care homes licensed by the
37.16 commissioner. The commissioner may adopt permanent rules to implement this section.

37.17 (b) Until federal regulations are adopted under sections 1819(f)(3) and 1919(f)(3) of the
37.18 Social Security Act that govern appeals of the discharges or transfers of residents from
37.19 nursing homes and boarding care homes certified for participation in Medicare or medical
37.20 assistance, the commissioner shall provide hearings under sections 14.57 to 14.62 and the
37.21 rules adopted by the Office of Administrative Hearings governing contested cases. To appeal
37.22 the discharge or transfer, or notification of an intended discharge or transfer, a resident or
37.23 the resident's representative must request a hearing in writing no later than 30 days after
37.24 receiving written notice, which conforms to state and federal law, of the intended discharge
37.25 or transfer.

37.26 (c) Hearings under this section shall be held no later than 14 days after receipt of the
37.27 request for hearing, unless impractical to do so or unless the parties agree otherwise. Hearings
37.28 shall be held in the facility in which the resident resides, unless impractical to do so or unless
37.29 the parties agree otherwise.

37.30 (d) A resident who timely appeals a notice of discharge or transfer, and who resides in
37.31 a certified nursing home or boarding care home, may not be discharged or transferred by
37.32 the nursing home or boarding care home until resolution of the appeal. The commissioner

38.1 can order the facility to readmit the resident if the discharge or transfer was in violation of
38.2 state or federal law. If the resident is required to be hospitalized for medical necessity before
38.3 resolution of the appeal, the facility shall readmit the resident unless the resident's attending
38.4 physician or advanced practice registered nurse documents, in writing, why the resident's
38.5 specific health care needs cannot be met in the facility.

38.6 (e) The commissioner and Office of Administrative Hearings shall conduct the hearings
38.7 in compliance with the federal regulations described in paragraph (b), when adopted.

38.8 (f) Nothing in this section limits the right of a resident or the resident's representative
38.9 to request or receive assistance from the Office of Ombudsman for Long-Term Care or the
38.10 Office of Health Facility Complaints with respect to an intended discharge or transfer.

38.11 (g) A person required to inform a health care facility of the person's status as a registered
38.12 predatory offender under section 243.166, subdivision 4b, who knowingly fails to do so
38.13 shall be deemed to have endangered the safety of individuals in the facility under Code of
38.14 Federal Regulations, chapter 42, section 483.12. Notwithstanding paragraph (d), any appeal
38.15 of the notice and discharge shall not constitute a stay of the discharge.

38.16 Sec. 57. Minnesota Statutes 2018, section 144A.161, subdivision 5, is amended to read:

38.17 Subd. 5. **Licensee responsibilities related to sending the notice in subdivision 5a.** (a)
38.18 The licensee shall establish an interdisciplinary team responsible for coordinating and
38.19 implementing the plan. The interdisciplinary team shall include representatives from the
38.20 county social services agency, the Office of Ombudsman for Long-Term Care, the Office
38.21 of the Ombudsman for Mental Health and Developmental Disabilities, facility staff that
38.22 provide direct care services to the residents, and facility administration.

38.23 (b) Concurrent with the notice provided in subdivision 5a, the licensee shall provide an
38.24 updated resident census summary document to the county social services agency, the
38.25 Ombudsman for Long-Term Care, and the Ombudsman for Mental Health and Developmental
38.26 Disabilities that includes the following information on each resident to be relocated:

38.27 (1) resident name;

38.28 (2) date of birth;

38.29 (3) Social Security number;

38.30 (4) payment source and medical assistance identification number, if applicable;

38.31 (5) county of financial responsibility if the resident is enrolled in a Minnesota health
38.32 care program;

39.1 (6) date of admission to the facility;

39.2 (7) all current diagnoses;

39.3 (8) the name of and contact information for the resident's physician or advanced practice
39.4 registered nurse;

39.5 (9) the name and contact information for the resident's responsible party;

39.6 (10) the name of and contact information for any case manager, managed care coordinator,
39.7 or other care coordinator, if known;

39.8 (11) information on the resident's status related to commitment and probation; and

39.9 (12) the name of the managed care organization in which the resident is enrolled, if
39.10 known.

39.11 Sec. 58. Minnesota Statutes 2018, section 144A.161, subdivision 5a, is amended to read:

39.12 Subd. 5a. **Administrator and licensee responsibility to provide notice.** At least 60
39.13 days before the proposed date of closing, reduction, or change in operations as agreed to in
39.14 the plan, the administrator shall send a written notice of closure, reduction, or change in
39.15 operations to each resident being relocated, the resident's responsible party, the resident's
39.16 managed care organization if it is known, the county social services agency, the commissioner
39.17 of health, the commissioner of human services, the Office of Ombudsman for Long-Term
39.18 Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the
39.19 resident's attending physician or advanced practice registered nurse, and, in the case of a
39.20 complete facility closure, the Centers for Medicare and Medicaid Services regional office
39.21 designated representative. The notice must include the following:

39.22 (1) the date of the proposed closure, reduction, or change in operations;

39.23 (2) the contact information of the individual or individuals in the facility responsible for
39.24 providing assistance and information;

39.25 (3) notification of upcoming meetings for residents, responsible parties, and resident
39.26 and family councils to discuss the plan for relocation of residents;

39.27 (4) the contact information of the county social services agency contact person; and

39.28 (5) the contact information of the Office of Ombudsman for Long-Term Care and the
39.29 Office of Ombudsman for Mental Health and Developmental Disabilities.

40.1 Sec. 59. Minnesota Statutes 2018, section 144A.161, subdivision 5e, is amended to read:

40.2 Subd. 5e. **Licensee responsibility for site visits.** The licensee shall assist residents
40.3 desiring to make site visits to facilities with available beds or other appropriate living options
40.4 to which the resident may relocate, unless it is medically inadvisable, as documented by
40.5 the attending physician or advanced practice registered nurse in the resident's care record.
40.6 The licensee shall make available to the resident at no charge transportation for up to three
40.7 site visits to facilities or other living options within the county or contiguous counties.

40.8 Sec. 60. Minnesota Statutes 2018, section 144A.161, subdivision 5g, is amended to read:

40.9 Subd. 5g. **Licensee responsibilities for final written discharge notice and records**
40.10 **transfer.** (a) The licensee shall provide the resident, the resident's responsible parties, the
40.11 resident's managed care organization, if known, and the resident's attending physician or
40.12 advanced practice registered nurse with a final written discharge notice prior to the relocation
40.13 of the resident. The notice must:

40.14 (1) be provided prior to the actual relocation; and

40.15 (2) identify the effective date of the anticipated relocation and the destination to which
40.16 the resident is being relocated.

40.17 (b) The licensee shall provide the receiving facility or other health, housing, or care
40.18 entity with complete and accurate resident records including contact information for family
40.19 members, responsible parties, social service or other caseworkers, and managed care
40.20 coordinators. These records must also include all information necessary to provide appropriate
40.21 medical care and social services. This includes, but is not limited to, information on
40.22 preadmission screening, Level I and Level II screening, minimum data set (MDS), all other
40.23 assessments, current resident diagnoses, social, behavioral, and medication information,
40.24 required forms, and discharge summaries.

40.25 (c) For residents with special care needs, the licensee shall consult with the receiving
40.26 facility or other placement entity and provide staff training or other preparation as needed
40.27 to assist in providing for the special needs.

40.28 Sec. 61. Minnesota Statutes 2018, section 144A.75, subdivision 3, is amended to read:

40.29 Subd. 3. **Core services.** "Core services" means physician services, registered nursing
40.30 services, advanced practice registered nurse services, medical social services, and counseling
40.31 services. A hospice must ensure that at least two core services are regularly provided directly
40.32 by hospice employees. A hospice provider may use contracted staff if necessary to

41.1 supplement hospice employees in order to meet the needs of patients during peak patient
41.2 loads or under extraordinary circumstances.

41.3 Sec. 62. Minnesota Statutes 2018, section 144A.75, subdivision 6, is amended to read:

41.4 Subd. 6. **Hospice patient.** "Hospice patient" means an individual whose illness has been
41.5 documented by the individual's attending physician or advanced practice registered nurse
41.6 and hospice medical director, who alone or, when unable, through the individual's family
41.7 has voluntarily consented to and received admission to a hospice provider, and who:

41.8 (1) has been diagnosed as terminally ill, with a probable life expectancy of under one
41.9 year; or

41.10 (2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and
41.11 life-threatening illness contributing to a shortened life expectancy; and is not expected to
41.12 survive to adulthood.

41.13 Sec. 63. Minnesota Statutes 2018, section 144A.752, subdivision 1, is amended to read:

41.14 Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of hospice
41.15 providers according to sections 144A.75 to 144A.755. The rules shall include the following:

41.16 (1) provisions to ensure, to the extent possible, the health, safety, well-being, and
41.17 appropriate treatment of persons who receive hospice care;

41.18 (2) requirements that hospice providers furnish the commissioner with specified
41.19 information necessary to implement sections 144A.75 to 144A.755;

41.20 (3) standards of training of hospice provider personnel;

41.21 (4) standards for medication management, which may vary according to the nature of
41.22 the hospice care provided, the setting in which the hospice care is provided, or the status of
41.23 the patient;

41.24 (5) standards for hospice patient and hospice patient's family evaluation or assessment,
41.25 which may vary according to the nature of the hospice care provided or the status of the
41.26 patient; and

41.27 (6) requirements for the involvement of a patient's physician or advanced practice
41.28 registered nurse; documentation of physicians' or advanced practice registered nurses' orders,
41.29 if required, and the patient's hospice plan of care; and maintenance of accurate, current
41.30 clinical records.

Sec. 64. Minnesota Statutes 2018, section 145.853, subdivision 5, is amended to read:

Subd. 5. **Notification; medical care.** A law enforcement officer who determines or has reason to believe that a disabled person is suffering from an illness causing the person's condition shall promptly notify the person's physician or advanced practice registered nurse, if practicable. If the officer is unable to ascertain the physician's or advanced practice registered nurse's identity or to communicate with the physician or advanced practice registered nurse, the officer shall make a reasonable effort to cause the disabled person to be transported immediately to a medical practitioner or to a facility where medical treatment is available. If the officer believes it unduly dangerous to move the disabled person, the officer shall make a reasonable effort to obtain the assistance of a medical practitioner.

Sec. 65. Minnesota Statutes 2018, section 145.892, subdivision 3, is amended to read:

Subd. 3. **Pregnant woman.** "Pregnant woman" means an individual determined by a licensed physician, advanced practice registered nurse, midwife, or appropriately trained registered nurse to have one or more fetuses in utero.

Sec. 66. Minnesota Statutes 2018, section 145.94, subdivision 2, is amended to read:

Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or to the community, information including data made nonpublic by law, relating to the hazardous properties and health hazards of hazardous substances released from a workplace if the commissioner finds:

(1) evidence that a person requesting the information may have suffered or is likely to suffer illness or injury from exposure to a hazardous substance; or

(2) evidence of a community health risk and if the commissioner seeks to have the employer cease an activity which results in release of a hazardous substance.

Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage according to established standards to prevent unauthorized use or disclosure. If the nonpublic data is required for the diagnosis, treatment, or prevention of illness or injury, a personal physician or advanced practice registered nurse may be provided with this information if the physician or advanced practice registered nurse agrees to preserve the confidentiality of the information, except for patient health records subject to sections 144.291 to 144.298. After the disclosure of any hazardous substance information relating to a particular workplace, the commissioner shall advise the employer of the information disclosed, the date of the disclosure, and the person who received the information.

43.1 Sec. 67. Minnesota Statutes 2018, section 145B.13, is amended to read:

43.2 **145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.**

43.3 In reliance on a patient's living will, a decision to administer, withhold, or withdraw
43.4 medical treatment after the patient has been diagnosed by the attending physician or advanced
43.5 practice registered nurse to be in a terminal condition must always be based on reasonable
43.6 medical practice, including:

43.7 (1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human
43.8 dignity and to alleviate pain;

43.9 (2) oral administration of food or water to a patient who accepts it, except for clearly
43.10 documented medical reasons; and

43.11 (3) in the case of a living will of a patient that the attending physician or advanced
43.12 practice registered nurse knows is pregnant, the living will must not be given effect as long
43.13 as it is possible that the fetus could develop to the point of live birth with continued
43.14 application of life-sustaining treatment.

43.15 Sec. 68. Minnesota Statutes 2018, section 145C.02, is amended to read:

43.16 **145C.02 HEALTH CARE DIRECTIVE.**

43.17 A principal with the capacity to do so may execute a health care directive. A health care
43.18 directive may include one or more health care instructions to direct health care providers,
43.19 others assisting with health care, family members, and a health care agent. A health care
43.20 directive may include a health care power of attorney to appoint a health care agent to make
43.21 health care decisions for the principal when the principal, in the judgment of the principal's
43.22 attending physician or advanced practice registered nurse, lacks decision-making capacity,
43.23 unless otherwise specified in the health care directive.

43.24 Sec. 69. Minnesota Statutes 2019 Supplement, section 145C.05, subdivision 2, is amended
43.25 to read:

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

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

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

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

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

44.10 (5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter
44.11 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

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

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

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

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

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

44.24 (11) health care instructions regarding artificially administered nutrition or hydration;
44.25 and

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

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

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

45.5 (2) a principal who in good faith does not generally select a physician or advanced
45.6 practice registered nurse or a health care facility for the principal's health care needs may
45.7 include a statement appointing an individual who may determine the principal's
45.8 decision-making capacity, provided that if the need to determine the principal's capacity
45.9 arises when the principal is receiving care under the direction of an attending physician or
45.10 advanced practice registered nurse in a health care facility, the determination must be made
45.11 by an attending physician or advanced practice registered nurse after consultation with the
45.12 appointed individual.

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

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

45.19 Sec. 70. Minnesota Statutes 2018, section 145C.06, is amended to read:

45.20 **145C.06 WHEN EFFECTIVE.**

45.21 A health care directive is effective for a health care decision when:

45.22 (1) it meets the requirements of section 145C.03, subdivision 1; and

45.23 (2) the principal, in the determination of the attending physician or advanced practice
45.24 registered nurse of the principal, lacks decision-making capacity to make the health care
45.25 decision; or if other conditions for effectiveness otherwise specified by the principal have
45.26 been met.

45.27 A health care directive is not effective for a health care decision when the principal, in
45.28 the determination of the attending physician or advanced practice registered nurse of the
45.29 principal, recovers decision-making capacity; or if other conditions for effectiveness
45.30 otherwise specified by the principal have been met.

46.1 Sec. 71. Minnesota Statutes 2018, section 145C.07, subdivision 1, is amended to read:

46.2 Subdivision 1. **Authority.** The health care agent has authority to make any particular
46.3 health care decision only if the principal lacks decision-making capacity, in the determination
46.4 of the attending physician or advanced practice registered nurse, to make or communicate
46.5 that health care decision; or if other conditions for effectiveness otherwise specified by the
46.6 principal have been met. The physician, advanced practice registered nurse, or other health
46.7 care provider shall continue to obtain the principal's informed consent to all health care
46.8 decisions for which the principal has decision-making capacity, unless other conditions for
46.9 effectiveness otherwise specified by the principal have been met. An alternate health care
46.10 agent has authority to act if the primary health care agent is not reasonably available to act.

46.11 Sec. 72. Minnesota Statutes 2018, section 145C.16, is amended to read:

46.12 **145C.16 SUGGESTED FORM.**

46.13 The following is a suggested form of a health care directive and is not a required form.

46.14 HEALTH CARE DIRECTIVE

46.15 I, ..., understand this document allows me to do ONE OR BOTH of the
46.16 following:

46.17 PART I: Name another person (called the health care agent) to make health care decisions
46.18 for me if I am unable to decide or speak for myself. My health care agent must make health
46.19 care decisions for me based on the instructions I provide in this document (Part II), if any,
46.20 the wishes I have made known to him or her, or must act in my best interest if I have not
46.21 made my health care wishes known.

46.22 AND/OR

46.23 PART II: Give health care instructions to guide others making health care decisions for
46.24 me. If I have named a health care agent, these instructions are to be used by the agent. These
46.25 instructions may also be used by my health care providers, others assisting with my health
46.26 care and my family, in the event I cannot make decisions for myself.

46.27 PART I: APPOINTMENT OF HEALTH CARE AGENT

46.28 THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
46.29 FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

46.30 (I know I can change my agent or alternate agent at any time and I know I do not have
46.31 to appoint an agent or an alternate agent)

47.1 NOTE: If you appoint an agent, you should discuss this health care directive with your agent
47.2 and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I
47.3 blank and go to Part II.

47.4 When I am unable to decide or speak for myself, I trust and appoint .... to
47.5 make health care decisions for me. This person is called my health care agent.

47.6 Relationship of my health care agent to me:..

47.7 Telephone number of my health care agent:..

47.8 Address of my health care agent:..

47.9 (OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my
47.10 health care agent is not reasonably available, I trust and appoint .... to be my health
47.11 care agent instead.

47.12 Relationship of my alternate health care agent to me:..

47.13 Telephone number of my alternate health care agent:..

47.14 Address of my alternate health care agent:...

47.15 THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO
47.16 DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF
47.17 (I know I can change these choices)

47.18 My health care agent is automatically given the powers listed below in (A) through (D).
47.19 My health care agent must follow my health care instructions in this document or any other
47.20 instructions I have given to my agent. If I have not given health care instructions, then my
47.21 agent must act in my best interest.

47.22 Whenever I am unable to decide or speak for myself, my health care agent has the power
47.23 to:

47.24 (A) Make any health care decision for me. This includes the power to give, refuse, or
47.25 withdraw consent to any care, treatment, service, or procedures. This includes deciding
47.26 whether to stop or not start health care that is keeping me or might keep me alive, and
47.27 deciding about intrusive mental health treatment.

47.28 (B) Choose my health care providers.

47.29 (C) Choose where I live and receive care and support when those choices relate to my
47.30 health care needs.

48.1 (D) Review my medical records and have the same rights that I would have to give my
48.2 medical records to other people.

48.3 If I DO NOT want my health care agent to have a power listed above in (A) through (D)
48.4 OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

48.5 ....

48.6 ....

48.7 ....

48.8 My health care agent is NOT automatically given the powers listed below in (1) and (2).
48.9 If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in
48.10 front of the power; then my agent WILL HAVE that power.

48.11 ...... (1) To decide whether to donate any parts of my body, including organs, tissues,
48.12 and eyes, when I die.

48.13 ...... (2) To decide what will happen with my body when I die (burial, cremation).

48.14 If I want to say anything more about my health care agent's powers or limits on the
48.15 powers, I can say it here:

48.16 ....

48.17 ....

48.18 ....

48.19 PART II: HEALTH CARE INSTRUCTIONS

48.20 NOTE: Complete this Part II if you wish to give health care instructions. If you appointed
48.21 an agent in Part I, completing this Part II is optional but would be very helpful to your agent.
48.22 However, if you chose not to appoint an agent in Part I, you MUST complete some or all
48.23 of this Part II if you wish to make a valid health care directive.

48.24 These are instructions for my health care when I am unable to decide or speak for myself.
48.25 These instructions must be followed (so long as they address my needs).

48.26 THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

48.27 (I know I can change these choices or leave any of them blank)

48.28 I want you to know these things about me to help you make decisions about my health
48.29 care:

48.30 My goals for my health care:...

48.31 ....

49.1 ....

49.2 My fears about my health care:...

49.3 ....

49.4 ....

49.5 My spiritual or religious beliefs and traditions:...

49.6 ....

49.7 ....

49.8 My beliefs about when life would be no longer worth living:...............................

49.9 ....

49.10 ....

49.11 My thoughts about how my medical condition might affect my family:

49.12 ....

49.13 ....

49.14 THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

49.15 (I know I can change these choices or leave any of them blank)

49.16 Many medical treatments may be used to try to improve my medical condition or to
49.17 prolong my life. Examples include artificial breathing by a machine connected to a tube in
49.18 the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries,
49.19 dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a
49.20 while and then stopped if they do not help.

49.21 I have these views about my health care in these situations:

49.22 (Note: You can discuss general feelings, specific treatments, or leave any of them blank)

49.23 If I had a reasonable chance of recovery, and were temporarily unable to decide or speak
49.24 for myself, I would want:...

49.25 ....

49.26 ....

49.27 If I were dying and unable to decide or speak for myself, I would want:.......................

49.28 ....

50.1 ....

50.2 If I were permanently unconscious and unable to decide or speak for myself, I would
50.3 want:..

50.4 ....

50.5 ....

50.6 If I were completely dependent on others for my care and unable to decide or speak for
50.7 myself, I would want:...

50.8 ....

50.9 ....

50.10 In all circumstances, my doctors or advanced practice registered nurses will try to keep
50.11 me comfortable and reduce my pain. This is how I feel about pain relief if it would affect
50.12 my alertness or if it could shorten my life:...

50.13 ....

50.14 ....

50.15 There are other things that I want or do not want for my health care, if possible:

50.16 Who I would like to be my doctor or advanced practice registered nurse:......................

50.17 ....

50.18 ....

50.19 Where I would like to live to receive health care:..

50.20 ....

50.21 ....

50.22 Where I would like to die and other wishes I have about dying:...................................

50.23 ....

50.24 ....

50.25 My wishes about donating parts of my body when I die:...

50.26 ....

50.27 ....

50.28 My wishes about what happens to my body when I die (cremation, burial):..................

51.1 ....

51.2 ....

51.3 Any other things:..

51.4 ....

51.5 ....

51.6 PART III: MAKING THE DOCUMENT LEGAL

51.7 This document must be signed by me. It also must either be verified by a notary public
51.8 (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified
51.9 or witnessed.

51.10 I am thinking clearly, I agree with everything that is written in this document, and I have
51.11 made this document willingly.

51.12 ....

51.13 My Signature

51.14 Date signed: ....

51.15 Date of birth: ....

51.16 Address: ....

51.17 ....

51.18 If I cannot sign my name, I can ask someone to sign this document for me.

51.19 ....

51.20 Signature of the person who I asked to sign this document for me.

51.21 ....

51.22 Printed name of the person who I asked to sign this document for me.

51.23 Option 1: Notary Public

51.24 In my presence on .... (date), ... (name) acknowledged his/her
51.25 signature on this document or acknowledged that he/she authorized the person signing this
51.26 document to sign on his/her behalf. I am not named as a health care agent or alternate health
51.27 care agent in this document.

51.28 ....

51.29 (Signature of Notary) (Notary Stamp)

51.30 Option 2: Two Witnesses

52.1 Two witnesses must sign. Only one of the two witnesses can be a health care provider
52.2 or an employee of a health care provider giving direct care to me on the day I sign this
52.3 document.

52.4 Witness One:

52.5 (i) In my presence on .... (date), ... (name) acknowledged his/her signature
52.6 on this document or acknowledged that he/she authorized the person signing this document
52.7 to sign on his/her behalf.

52.8 (ii) I am at least 18 years of age.

52.9 (iii) I am not named as a health care agent or an alternate health care agent in this
52.10 document.

52.11 (iv) If I am a health care provider or an employee of a health care provider giving direct
52.12 care to the person listed above in (A), I must initial this box: [ ]

52.13 I certify that the information in (i) through (iv) is true and correct.

52.14 ....

52.15 (Signature of Witness One)

52.16 Address: ....

52.17 ....

52.18 Witness Two:

52.19 (i) In my presence on .... (date), ... (name) acknowledged his/her signature
52.20 on this document or acknowledged that he/she authorized the person signing this document
52.21 to sign on his/her behalf.

52.22 (ii) I am at least 18 years of age.

52.23 (iii) I am not named as a health care agent or an alternate health care agent in this
52.24 document.

52.25 (iv) If I am a health care provider or an employee of a health care provider giving direct
52.26 care to the person listed above in (A), I must initial this box: [ ]

52.27 I certify that the information in (i) through (iv) is true and correct.

52.28 ....

52.29 (Signature of Witness Two)

52.30 Address: ....

52.31 ....

53.1 REMINDER: Keep this document with your personal papers in a safe place (not in a safe
53.2 deposit box). Give signed copies to your doctors or advanced practice registered nurses,
53.3 family, close friends, health care agent, and alternate health care agent. Make sure your
53.4 doctor or advanced practice registered nurse is willing to follow your wishes. This document
53.5 should be part of your medical record at your physician's or advanced practice registered
53.6 nurse's office and at the hospital, home care agency, hospice, or nursing facility where you
53.7 receive your care.

53.8 Sec. 73. Minnesota Statutes 2018, section 148.6438, subdivision 1, is amended to read:

53.9 Subdivision 1. **Required notification.** In the absence of a physician or advanced practice
53.10 registered nurse referral or prior authorization, and before providing occupational therapy
53.11 services for remuneration or expectation of payment from the client, an occupational therapist
53.12 must provide the following written notification in all capital letters of 12-point or larger
53.13 boldface type, to the client, parent, or guardian:

53.14 "Your health care provider, insurer, or plan may require a physician or advanced practice
53.15 registered nurse referral or prior authorization and you may be obligated for partial or full
53.16 payment for occupational therapy services rendered."

53.17 Information other than this notification may be included as long as the notification
53.18 remains conspicuous on the face of the document. A nonwritten disclosure format may be
53.19 used to satisfy the recipient notification requirement when necessary to accommodate the
53.20 physical condition of a client or client's guardian.

53.21 Sec. 74. Minnesota Statutes 2018, section 151.19, subdivision 4, is amended to read:

53.22 Subd. 4. **Licensing of physicians and advanced practice registered nurses to dispense**
53.23 **drugs; renewals.** (a) The board may grant a license to any physician licensed under chapter
53.24 147 or advanced practice registered nurse licensed under chapter 148 who provides services
53.25 in a health care facility located in a designated health professional shortage area authorizing
53.26 the physician or advanced practice registered nurse to dispense drugs to individuals for
53.27 whom pharmaceutical care is not reasonably available. The license may be renewed annually.
53.28 Any physician or advanced practice registered nurse licensed under this subdivision shall
53.29 be limited to dispensing drugs in a limited service pharmacy and shall be governed by the
53.30 rules adopted by the board when dispensing drugs.

53.31 (b) For the purposes of this subdivision, pharmaceutical care is not reasonably available
53.32 if the limited service pharmacy in which the physician or advanced practice registered nurse

54.1 is dispensing drugs is located in a health professional shortage area, and no other licensed
54.2 pharmacy is located within 15 miles of the limited service pharmacy.

54.3 (c) For the purposes of this subdivision, section 151.15, subdivision 2, shall not apply,
54.4 and section 151.215 shall not apply provided that a physician or advanced practice registered
54.5 nurse granted a license under this subdivision certifies each filled prescription in accordance
54.6 with Minnesota Rules, part 6800.3100, subpart 3.

54.7 (d) Notwithstanding section 151.102, a physician or advanced practice registered nurse
54.8 granted a license under this subdivision may be assisted by a pharmacy technician if the
54.9 technician holds a valid certification from the Pharmacy Technician Certification Board or
54.10 from another national certification body for pharmacy technicians that requires passage of
54.11 a nationally recognized psychometrically valid certification examination for certification
54.12 as determined by the board. The physician or advanced practice registered nurse may
54.13 supervise the pharmacy technician as long as the physician or advanced practice registered
54.14 nurse assumes responsibility for all functions performed by the technician. For purposes of
54.15 this subdivision, supervision does not require the physician or advanced practice registered
54.16 nurse to be physically present if the physician, advanced practice registered nurse, or a
54.17 licensed pharmacist is available, either electronically or by telephone.

54.18 (e) Nothing in this subdivision shall be construed to prohibit a physician or advanced
54.19 practice registered nurse from dispensing drugs pursuant to section 151.37 and Minnesota
54.20 Rules, parts 6800.9950 to 6800.9954.

54.21 Sec. 75. Minnesota Statutes 2018, section 151.21, subdivision 4a, is amended to read:

54.22 Subd. 4a. **Sign.** A pharmacy must post a sign in a conspicuous location and in a typeface
54.23 easily seen at the counter where prescriptions are dispensed stating: "In order to save you
54.24 money, this pharmacy will substitute whenever possible an FDA-approved, less expensive,
54.25 generic drug product, which is therapeutically equivalent to and safely interchangeable with
54.26 the one prescribed by your doctor or advanced practice registered nurse, unless you object
54.27 to this substitution."

54.28 Sec. 76. Minnesota Statutes 2018, section 152.32, subdivision 3, is amended to read:

54.29 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
54.30 lease to and may not otherwise penalize a person solely for the person's status as a patient
54.31 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
54.32 would violate federal law or regulations or cause the school or landlord to lose a monetary
54.33 or licensing-related benefit under federal law or regulations.

55.1 (b) For the purposes of medical care, including organ transplants, a registry program
55.2 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
55.3 equivalent of the authorized use of any other medication used at the discretion of a physician
55.4 or advanced practice registered nurse and does not constitute the use of an illicit substance
55.5 or otherwise disqualify a patient from needed medical care.

55.6 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
55.7 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
55.8 may not discriminate against a person in hiring, termination, or any term or condition of
55.9 employment, or otherwise penalize a person, if the discrimination is based upon either of
55.10 the following:

55.11 (1) the person's status as a patient enrolled in the registry program under sections 152.22
55.12 to 152.37; or

55.13 (2) a patient's positive drug test for cannabis components or metabolites, unless the
55.14 patient used, possessed, or was impaired by medical cannabis on the premises of the place
55.15 of employment or during the hours of employment.

55.16 (d) An employee who is required to undergo employer drug testing pursuant to section
55.17 181.953 may present verification of enrollment in the patient registry as part of the employee's
55.18 explanation under section 181.953, subdivision 6.

55.19 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
55.20 time with a minor child solely based on the person's status as a patient enrolled in the registry
55.21 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
55.22 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
55.23 behavior is such that it creates an unreasonable danger to the safety of the minor as
55.24 established by clear and convincing evidence.

55.25 Sec. 77. Minnesota Statutes 2018, section 245A.143, subdivision 8, is amended to read:

55.26 Subd. 8. **Nutritional services.** (a) The license holder shall ensure that food served is
55.27 nutritious and meets any special dietary needs of the participants as prescribed by the
55.28 participant's physician, advanced practice registered nurse, or dietitian as specified in the
55.29 service delivery plan.

55.30 (b) Food and beverages must be obtained, handled, and properly stored to prevent
55.31 contamination, spoilage, or a threat to the health of a resident.

56.1 Sec. 78. Minnesota Statutes 2018, section 245A.1435, is amended to read:

56.2 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH**
56.3 **IN LICENSED PROGRAMS.**

56.4 (a) When a license holder is placing an infant to sleep, the license holder must place the
56.5 infant on the infant's back, unless the license holder has documentation from the infant's
56.6 physician or advanced practice registered nurse directing an alternative sleeping position
56.7 for the infant. The physician or advanced practice registered nurse directive must be on a
56.8 form approved by the commissioner and must remain on file at the licensed location. An
56.9 infant who independently rolls onto its stomach after being placed to sleep on its back may
56.10 be allowed to remain sleeping on its stomach if the infant is at least six months of age or
56.11 the license holder has a signed statement from the parent indicating that the infant regularly
56.12 rolls over at home.

56.13 (b) The license holder must place the infant in a crib directly on a firm mattress with a
56.14 fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and
56.15 overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of
56.16 the sheet with reasonable effort. The license holder must not place anything in the crib with
56.17 the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title
56.18 16, part 1511. The requirements of this section apply to license holders serving infants
56.19 younger than one year of age. Licensed child care providers must meet the crib requirements
56.20 under section 245A.146. A correction order shall not be issued under this paragraph unless
56.21 there is evidence that a violation occurred when an infant was present in the license holder's
56.22 care.

56.23 (c) If an infant falls asleep before being placed in a crib, the license holder must move
56.24 the infant to a crib as soon as practicable, and must keep the infant within sight of the license
56.25 holder until the infant is placed in a crib. When an infant falls asleep while being held, the
56.26 license holder must consider the supervision needs of other children in care when determining
56.27 how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant
56.28 must not be in a position where the airway may be blocked or with anything covering the
56.29 infant's face.

56.30 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
56.31 for an infant of any age and is prohibited for any infant who has begun to roll over
56.32 independently. However, with the written consent of a parent or guardian according to this
56.33 paragraph, a license holder may place the infant who has not yet begun to roll over on its
56.34 own down to sleep in a one-piece sleeper equipped with an attached system that fastens

57.1 securely only across the upper torso, with no constriction of the hips or legs, to create a
57.2 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
57.3 the license holder must obtain informed written consent for the use of swaddling from the
57.4 parent or guardian of the infant on a form provided by the commissioner and prepared in
57.5 partnership with the Minnesota Sudden Infant Death Center.

57.6 Sec. 79. Minnesota Statutes 2018, section 245C.02, subdivision 18, is amended to read:

57.7 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
57.8 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
57.9 the care of a physician or advanced practice registered nurse whether or not the care of a
57.10 physician or advanced practice registered nurse was sought, or abuse resulting in serious
57.11 injury.

57.12 (b) For purposes of this definition, "care of a physician or advanced practice registered
57.13 nurse" is treatment received or ordered by a physician, physician assistant, advanced practice
57.14 registered nurse, or nurse practitioner, but does not include:

57.15 (1) diagnostic testing, assessment, or observation;

57.16 (2) the application of, recommendation to use, or prescription solely for a remedy that
57.17 is available over the counter without a prescription; or

57.18 (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up
57.19 appointment.

57.20 (c) For purposes of this definition, "abuse resulting in serious injury" means: bruises,
57.21 bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries;
57.22 head injuries with loss of consciousness; extensive second-degree or third-degree burns and
57.23 other burns for which complications are present; extensive second-degree or third-degree
57.24 frostbite and other frostbite for which complications are present; irreversible mobility or
57.25 avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are
57.26 harmful; near drowning; and heat exhaustion or sunstroke.

57.27 (d) Serious maltreatment includes neglect when it results in criminal sexual conduct
57.28 against a child or vulnerable adult.

57.29 Sec. 80. Minnesota Statutes 2018, section 245C.04, subdivision 1, is amended to read:

57.30 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
57.31 shall conduct a background study of an individual required to be studied under section
57.32 245C.03, subdivision 1, at least upon application for initial license for all license types.

58.1 (b) The commissioner shall conduct a background study of an individual required to be
58.2 studied under section 245C.03, subdivision 1, including a child care background study
58.3 subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed
58.4 child care center, certified license-exempt child care center, or legal nonlicensed child care
58.5 provider, on a schedule determined by the commissioner. Except as provided in section
58.6 245C.05, subdivision 5a, a child care background study must include submission of
58.7 fingerprints for a national criminal history record check and a review of the information
58.8 under section 245C.08. A background study for a child care program must be repeated
58.9 within five years from the most recent study conducted under this paragraph.

58.10 (c) At reapplication for a family child care license:

58.11 (1) for a background study affiliated with a licensed family child care center or legal
58.12 nonlicensed child care provider, the individual shall provide information required under
58.13 section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be
58.14 fingerprinted and photographed under section 245C.05, subdivision 5;

58.15 (2) the county agency shall verify the information received under clause (1) and forward
58.16 the information to the commissioner to complete the background study; and

58.17 (3) the background study conducted by the commissioner under this paragraph must
58.18 include a review of the information required under section 245C.08.

58.19 (d) The commissioner is not required to conduct a study of an individual at the time of
58.20 reapplication for a license if the individual's background study was completed by the
58.21 commissioner of human services and the following conditions are met:

58.22 (1) a study of the individual was conducted either at the time of initial licensure or when
58.23 the individual became affiliated with the license holder;

58.24 (2) the individual has been continuously affiliated with the license holder since the last
58.25 study was conducted; and

58.26 (3) the last study of the individual was conducted on or after October 1, 1995.

58.27 (e) The commissioner of human services shall conduct a background study of an
58.28 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),
58.29 who is newly affiliated with a child foster care license holder:

58.30 (1) the county or private agency shall collect and forward to the commissioner the
58.31 information required under section 245C.05, subdivisions 1 and 5, when the child foster
58.32 care applicant or license holder resides in the home where child foster care services are
58.33 provided;

59.1 (2) the child foster care license holder or applicant shall collect and forward to the
59.2 commissioner the information required under section 245C.05, subdivisions 1 and 5, when
59.3 the applicant or license holder does not reside in the home where child foster care services
59.4 are provided; and

59.5 (3) the background study conducted by the commissioner of human services under this
59.6 paragraph must include a review of the information required under section 245C.08,
59.7 subdivisions 1, 3, and 4.

59.8 (f) The commissioner shall conduct a background study of an individual specified under
59.9 section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated
59.10 with an adult foster care or family adult day services and with a family child care license
59.11 holder or a legal nonlicensed child care provider authorized under chapter 119B and:

59.12 (1) except as provided in section 245C.05, subdivision 5a, the county shall collect and
59.13 forward to the commissioner the information required under section 245C.05, subdivision
59.14 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a), (b), and (d), for background
59.15 studies conducted by the commissioner for all family adult day services, for adult foster
59.16 care when the adult foster care license holder resides in the adult foster care residence, and
59.17 for family child care and legal nonlicensed child care authorized under chapter 119B;

59.18 (2) the license holder shall collect and forward to the commissioner the information
59.19 required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs
59.20 (a) and (b), for background studies conducted by the commissioner for adult foster care
59.21 when the license holder does not reside in the adult foster care residence; and

59.22 (3) the background study conducted by the commissioner under this paragraph must
59.23 include a review of the information required under section 245C.08, subdivision 1, paragraph
59.24 (a), and subdivisions 3 and 4.

59.25 (g) Applicants for licensure, license holders, and other entities as provided in this chapter
59.26 must submit completed background study requests to the commissioner using the electronic
59.27 system known as NETStudy before individuals specified in section 245C.03, subdivision
59.28 1, begin positions allowing direct contact in any licensed program.

59.29 (h) For an individual who is not on the entity's active roster, the entity must initiate a
59.30 new background study through NETStudy when:

59.31 (1) an individual returns to a position requiring a background study following an absence
59.32 of 120 or more consecutive days; or

60.1 (2) a program that discontinued providing licensed direct contact services for 120 or
60.2 more consecutive days begins to provide direct contact licensed services again.

60.3 The license holder shall maintain a copy of the notification provided to the commissioner
60.4 under this paragraph in the program's files. If the individual's disqualification was previously
60.5 set aside for the license holder's program and the new background study results in no new
60.6 information that indicates the individual may pose a risk of harm to persons receiving
60.7 services from the license holder, the previous set-aside shall remain in effect.

60.8 (i) For purposes of this section, a physician licensed under chapter 147 or advanced
60.9 practice registered nurse licensed under chapter 148 is considered to be continuously affiliated
60.10 upon the license holder's receipt from the commissioner of health or human services of the
60.11 physician's or advanced practice registered nurse's background study results.

60.12 (j) For purposes of family child care, a substitute caregiver must receive repeat
60.13 background studies at the time of each license renewal.

60.14 (k) A repeat background study at the time of license renewal is not required if the family
60.15 child care substitute caregiver's background study was completed by the commissioner on
60.16 or after October 1, 2017, and the substitute caregiver is on the license holder's active roster
60.17 in NETStudy 2.0.

60.18 (l) Before and after school programs authorized under chapter 119B, are exempt from
60.19 the background study requirements under section 123B.03, for an employee for whom a
60.20 background study under this chapter has been completed.

60.21 Sec. 81. Minnesota Statutes 2018, section 245D.02, subdivision 11, is amended to read:

60.22 Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires
60.23 the program to make a response that is not a part of the program's ordinary provision of
60.24 services to that person, and includes:

60.25 (1) serious injury of a person as determined by section 245.91, subdivision 6;

60.26 (2) a person's death;

60.27 (3) any medical emergency, unexpected serious illness, or significant unexpected change
60.28 in an illness or medical condition of a person that requires the program to call 911, physician
60.29 or advanced practice registered nurse treatment, or hospitalization;

60.30 (4) any mental health crisis that requires the program to call 911, a mental health crisis
60.31 intervention team, or a similar mental health response team or service when available and
60.32 appropriate;

61.1 (5) an act or situation involving a person that requires the program to call 911, law
61.2 enforcement, or the fire department;

61.3 (6) a person's unauthorized or unexplained absence from a program;

61.4 (7) conduct by a person receiving services against another person receiving services
61.5 that:

61.6 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with a
61.7 person's opportunities to participate in or receive service or support;

61.8 (ii) places the person in actual and reasonable fear of harm;

61.9 (iii) places the person in actual and reasonable fear of damage to property of the person;
61.10 or

61.11 (iv) substantially disrupts the orderly operation of the program;

61.12 (8) any sexual activity between persons receiving services involving force or coercion
61.13 as defined under section 609.341, subdivisions 3 and 14;

61.14 (9) any emergency use of manual restraint as identified in section 245D.061 or successor
61.15 provisions; or

61.16 (10) a report of alleged or suspected child or vulnerable adult maltreatment under section
61.17 626.556 or 626.557.

61.18 Sec. 82. Minnesota Statutes 2018, section 245D.11, subdivision 2, is amended to read:

61.19 Subd. 2. **Health and welfare.** The license holder must establish policies and procedures
61.20 that promote health and welfare by ensuring:

61.21 (1) use of universal precautions and sanitary practices in compliance with section
61.22 245D.06, subdivision 2, clause (5);

61.23 (2) if the license holder operates a residential program, health service coordination and
61.24 care according to the requirements in section 245D.05, subdivision 1;

61.25 (3) safe medication assistance and administration according to the requirements in
61.26 sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
61.27 consultation with a registered nurse, ~~nurse practitioner~~ advanced practice registered nurse,
61.28 physician assistant, or medical doctor and require completion of medication administration
61.29 training according to the requirements in section 245D.09, subdivision 4a, paragraph (d).
61.30 Medication assistance and administration includes, but is not limited to:

61.31 (i) providing medication-related services for a person;

62.1 (ii) medication setup;

62.2 (iii) medication administration;

62.3 (iv) medication storage and security;

62.4 (v) medication documentation and charting;

62.5 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
62.6 handling and administration;

62.7 (vii) coordination of medication refills;

62.8 (viii) handling changes to prescriptions and implementation of those changes;

62.9 (ix) communicating with the pharmacy; and

62.10 (x) coordination and communication with prescriber;

62.11 (4) safe transportation, when the license holder is responsible for transportation of
62.12 persons, with provisions for handling emergency situations according to the requirements
62.13 in section 245D.06, subdivision 2, clauses (2) to (4);

62.14 (5) a plan for ensuring the safety of persons served by the program in emergencies as
62.15 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
62.16 to the license holder. A license holder with a community residential setting or a day service
62.17 facility license must ensure the policy and procedures comply with the requirements in
62.18 section 245D.22, subdivision 4;

62.19 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11;
62.20 and reporting all incidents required to be reported according to section 245D.06, subdivision
62.21 1. The plan must:

62.22 (i) provide the contact information of a source of emergency medical care and
62.23 transportation; and

62.24 (ii) require staff to first call 911 when the staff believes a medical emergency may be
62.25 life threatening, or to call the mental health crisis intervention team or similar mental health
62.26 response team or service when such a team is available and appropriate when the person is
62.27 experiencing a mental health crisis; and

62.28 (7) a procedure for the review of incidents and emergencies to identify trends or patterns,
62.29 and corrective action if needed. The license holder must establish and maintain a
62.30 record-keeping system for the incident and emergency reports. Each incident and emergency
62.31 report file must contain a written summary of the incident. The license holder must conduct

63.1 a review of incident reports for identification of incident patterns, and implementation of
63.2 corrective action as necessary to reduce occurrences. Each incident report must include:

63.3 (i) the name of the person or persons involved in the incident. It is not necessary to
63.4 identify all persons affected by or involved in an emergency unless the emergency resulted
63.5 in an incident;

63.6 (ii) the date, time, and location of the incident or emergency;

63.7 (iii) a description of the incident or emergency;

63.8 (iv) a description of the response to the incident or emergency and whether a person's
63.9 coordinated service and support plan addendum or program policies and procedures were
63.10 implemented as applicable;

63.11 (v) the name of the staff person or persons who responded to the incident or emergency;
63.12 and

63.13 (vi) the determination of whether corrective action is necessary based on the results of
63.14 the review.

63.15 Sec. 83. Minnesota Statutes 2018, section 245D.22, subdivision 7, is amended to read:

63.16 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin-operated
63.17 telephone that is readily accessible. A list of emergency numbers must be posted in a
63.18 prominent location. When an area has a 911 number or a mental health crisis intervention
63.19 team number, both numbers must be posted and the emergency number listed must be 911.
63.20 In areas of the state without a 911 number, the numbers listed must be those of the local
63.21 fire department, police department, emergency transportation, and poison control center.
63.22 The names and telephone numbers of each person's representative, physician or advanced
63.23 practice registered nurse, and dentist must be readily available.

63.24 Sec. 84. Minnesota Statutes 2018, section 245D.25, subdivision 2, is amended to read:

63.25 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed
63.26 by the person's physician, advanced practice registered nurse, or dietitian. Three nutritionally
63.27 balanced meals a day must be served or made available to persons, and nutritious snacks
63.28 must be available between meals.

63.29 Sec. 85. Minnesota Statutes 2018, section 245G.08, subdivision 2, is amended to read:

63.30 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
63.31 obtaining a medical intervention for a client, that are approved in writing by a physician

64.1 who is licensed under chapter 147 or advanced practice registered nurse who is licensed
64.2 under chapter 148, unless:

64.3 (1) the license holder does not provide a service under section 245G.21; and

64.4 (2) a medical intervention is referred to 911, the emergency telephone number, or the
64.5 client's physician or advanced practice registered nurse.

64.6 Sec. 86. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended
64.7 to read:

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

64.15 Sec. 87. Minnesota Statutes 2018, section 245G.08, subdivision 5, is amended to read:

64.16 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
64.17 license holder must meet the requirements in this subdivision if a service provided includes
64.18 the administration of medication.

64.19 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
64.20 licensed practitioner or a registered nurse the task of administration of medication or assisting
64.21 with self-medication, must:

64.22 (1) successfully complete a medication administration training program for unlicensed
64.23 personnel through an accredited Minnesota postsecondary educational institution. A staff
64.24 member's completion of the course must be documented in writing and placed in the staff
64.25 member's personnel file;

64.26 (2) be trained according to a formalized training program that is taught by a registered
64.27 nurse and offered by the license holder. The training must include the process for
64.28 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
64.29 training must be documented in writing and placed in the staff member's personnel records;
64.30 or

65.1 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
65.2 registered nurse must be employed or contracted to develop the policies and procedures for
65.3 administration of medication or assisting with self-administration of medication, or both.

65.4 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
65.5 23. The registered nurse's supervision must include, at a minimum, monthly on-site
65.6 supervision or more often if warranted by a client's health needs. The policies and procedures
65.7 must include:

65.8 (1) a provision that a delegation of administration of medication is limited to the
65.9 administration of a medication that is administered orally, topically, or as a suppository, an
65.10 eye drop, an ear drop, or an inhalant;

65.11 (2) a provision that each client's file must include documentation indicating whether
65.12 staff must conduct the administration of medication or the client must self-administer
65.13 medication, or both;

65.14 (3) a provision that a client may carry emergency medication such as nitroglycerin as
65.15 instructed by the client's physician <u>or advanced practice registered nurse</u>;

65.16 (4) a provision for the client to self-administer medication when a client is scheduled to
65.17 be away from the facility;

65.18 (5) a provision that if a client self-administers medication when the client is present in
65.19 the facility, the client must self-administer medication under the observation of a trained
65.20 staff member;

65.21 (6) a provision that when a license holder serves a client who is a parent with a child,
65.22 the parent may only administer medication to the child under a staff member's supervision;

65.23 (7) requirements for recording the client's use of medication, including staff signatures
65.24 with date and time;

65.25 (8) guidelines for when to inform a nurse of problems with self-administration of
65.26 medication, including a client's failure to administer, refusal of a medication, adverse
65.27 reaction, or error; and

65.28 (9) procedures for acceptance, documentation, and implementation of a prescription,
65.29 whether written, verbal, telephonic, or electronic.

65.30 Sec. 88. Minnesota Statutes 2018, section 245G.21, subdivision 2, is amended to read:

65.31 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
65.32 the license holder. The license holder must set and post a notice of visiting rules and hours,

66.1 including both day and evening times. A client's right to receive visitors other than a personal
66.2 physician or advanced practice registered nurse, religious adviser, county case manager,
66.3 parole or probation officer, or attorney may be subject to visiting hours established by the
66.4 license holder for all clients. The treatment director or designee may impose limitations as
66.5 necessary for the welfare of a client provided the limitation and the reasons for the limitation
66.6 are documented in the client's file. A client must be allowed to receive visits at all reasonable
66.7 times from the client's personal physician or advanced practice registered nurse, religious
66.8 adviser, county case manager, parole or probation officer, and attorney.

66.9 Sec. 89. Minnesota Statutes 2018, section 245G.21, subdivision 3, is amended to read:

66.10 Subd. 3. **Client property management.** A license holder who provides room and board
66.11 and treatment services to a client in the same facility, and any license holder that accepts
66.12 client property must meet the requirements for handling client funds and property in section
66.13 245A.04, subdivision 13. License holders:

66.14 (1) may establish policies regarding the use of personal property to ensure that treatment
66.15 activities and the rights of other clients are not infringed upon;

66.16 (2) may take temporary custody of a client's property for violation of a facility policy;

66.17 (3) must retain the client's property for a minimum of seven days after the client's service
66.18 termination if the client does not reclaim property upon service termination, or for a minimum
66.19 of 30 days if the client does not reclaim property upon service termination and has received
66.20 room and board services from the license holder; and

66.21 (4) must return all property held in trust to the client at service termination regardless
66.22 of the client's service termination status, except that:

66.23 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
66.24 609.5316, must be given to the custody of a local law enforcement agency. If giving the
66.25 property to the custody of a local law enforcement agency violates Code of Federal
66.26 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
66.27 paraphernalia, or drug container must be destroyed by a staff member designated by the
66.28 program director; and

66.29 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
66.30 others must be given to the custody of a local law enforcement agency, and the client must
66.31 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
66.32 and

67.1 (iii) a medication that was determined by a physician or advanced practice registered
67.2 nurse to be harmful after examining the client must be destroyed, except when the client's
67.3 personal physician or advanced practice registered nurse approves the medication for
67.4 continued use.

67.5 Sec. 90. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

67.6 **245H.11 REPORTING.**

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

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

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

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

67.15 Sec. 91. Minnesota Statutes 2018, section 246.711, subdivision 2, is amended to read:

67.16 Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections
67.17 246.71 to 246.722 when all of the following conditions are met:

67.18 (1) a licensed physician or advanced practice registered nurse determines that a significant
67.19 exposure has occurred following the protocol under section 246.721;

67.20 (2) the licensed physician or advanced practice registered nurse for the employee needs
67.21 the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue
67.22 treatment in accordance with the most current guidelines of the United States Public Health
67.23 Service, because of possible exposure to a blood-borne pathogen; and

67.24 (3) the employee consents to providing a blood sample for testing for a blood-borne
67.25 pathogen.

67.26 Sec. 92. Minnesota Statutes 2018, section 246.715, subdivision 2, is amended to read:

67.27 Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but
67.28 does not consent to blood-borne pathogens testing, the secure treatment facility shall ensure
67.29 that the blood is tested for blood-borne pathogens if the employee requests the test, provided
67.30 all of the following criteria are met:

68.1 (1) the employee and secure treatment facility have documented exposure to blood or
68.2 body fluids during performance of the employee's work duties;

68.3 (2) a licensed physician or advanced practice registered nurse has determined that a
68.4 significant exposure has occurred under section 246.711 and has documented that blood-borne
68.5 pathogen test results are needed for beginning, modifying, continuing, or discontinuing
68.6 medical treatment for the employee as recommended by the most current guidelines of the
68.7 United States Public Health Service;

68.8 (3) the employee provides a blood sample for testing for blood-borne pathogens as soon
68.9 as feasible;

68.10 (4) the secure treatment facility asks the patient to consent to a test for blood-borne
68.11 pathogens and the patient does not consent;

68.12 (5) the secure treatment facility has provided the patient and the employee with all of
68.13 the information required by section 246.712; and

68.14 (6) the secure treatment facility has informed the employee of the confidentiality
68.15 requirements of section 246.719 and the penalties for unauthorized release of patient
68.16 information under section 246.72.

68.17 Sec. 93. Minnesota Statutes 2018, section 246.716, subdivision 2, is amended to read:

68.18 Subd. 2. **Procedures without consent.** (a) A secure treatment facility or an employee
68.19 of a secure treatment facility may bring a petition for a court order to require a patient to
68.20 provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in
68.21 the district court in the county where the patient is receiving treatment from the secure
68.22 treatment facility. The secure treatment facility shall serve the petition on the patient three
68.23 days before a hearing on the petition. The petition shall include one or more affidavits
68.24 attesting that:

68.25 (1) the secure treatment facility followed the procedures in sections 246.71 to 246.722
68.26 and attempted to obtain blood-borne pathogen test results according to those sections;

68.27 (2) a licensed physician or advanced practice registered nurse knowledgeable about the
68.28 most current recommendations of the United States Public Health Service has determined
68.29 that a significant exposure has occurred to the employee of a secure treatment facility under
68.30 section 246.721; and

68.31 (3) a physician or advanced practice registered nurse has documented that the employee
68.32 has provided a blood sample and consented to testing for blood-borne pathogens and

69.1 blood-borne pathogen test results are needed for beginning, continuing, modifying, or
69.2 discontinuing medical treatment for the employee under section 246.721.

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

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

69.7 (1) there is probable cause to believe the employee of a secure treatment facility has
69.8 experienced a significant exposure to the patient;

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

69.12 (3) a licensed physician or advanced practice registered nurse for the employee of a
69.13 secure treatment facility needs the test results for beginning, continuing, modifying, or
69.14 discontinuing medical treatment for the employee; and

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

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

69.23 (e) The patient may arrange for counsel in any proceeding brought under this subdivision.

69.24 Sec. 94. Minnesota Statutes 2018, section 246.721, is amended to read:

69.25 **246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.**

69.26 (a) A secure treatment facility shall follow applicable Occupational Safety and Health
69.27 Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for
69.28 blood-borne pathogens.

69.29 (b) Every secure treatment facility shall adopt and follow a postexposure protocol for
69.30 employees at a secure treatment facility who have experienced a significant exposure. The
69.31 postexposure protocol must adhere to the most current recommendations of the United
69.32 States Public Health Service and include, at a minimum, the following:

70.1 (1) a process for employees to report an exposure in a timely fashion;

70.2 (2) a process for an infectious disease specialist, or a licensed physician or advanced
70.3 practice registered nurse who is knowledgeable about the most current recommendations
70.4 of the United States Public Health Service in consultation with an infectious disease specialist,
70.5 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
70.6 occurred, and (ii) to provide, under the direction of a licensed physician or advanced practice
70.7 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
70.8 to the particular blood-borne pathogen or pathogens for which a significant exposure has
70.9 been determined;

70.10 (3) if there has been a significant exposure, a process to determine whether the patient
70.11 has a blood-borne pathogen through disclosure of test results, or through blood collection
70.12 and testing as required by sections 246.71 to 246.722;

70.13 (4) a process for providing appropriate counseling prior to and following testing for a
70.14 blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and
70.15 follow-up recommendations according to the most current recommendations of the United
70.16 States Public Health Service, recommendations for testing, and treatment;

70.17 (5) a process for providing appropriate counseling under clause (4) to the employee of
70.18 a secure treatment facility and to the patient; and

70.19 (6) compliance with applicable state and federal laws relating to data practices,
70.20 confidentiality, informed consent, and the patient bill of rights.

70.21 Sec. 95. Minnesota Statutes 2018, section 246.722, is amended to read:

70.22 **246.722 IMMUNITY.**

70.23 A secure treatment facility, licensed physician or advanced practice registered nurse,
70.24 and designated health care personnel are immune from liability in any civil, administrative,
70.25 or criminal action relating to the disclosure of test results of a patient to an employee of a
70.26 secure treatment facility and the testing of a blood sample from the patient for blood-borne
70.27 pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

70.28 Sec. 96. Minnesota Statutes 2018, section 251.043, subdivision 1, is amended to read:

70.29 Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in the preceding
70.30 section, the workers' compensation division finds that an employee is suffering from
70.31 tuberculosis contracted in the institution or department by contact with inmates or patients
70.32 therein or by contact with tuberculosis contaminated material therein, it shall order the

71.1 employee to seek the services of a physician, advanced practice registered nurse, or medical
71.2 care facility. There shall be paid to the physician, advanced practice registered nurse, or
71.3 facility where the employee may be received, the same fee for the maintenance and care of
71.4 the person as is received by the institution for the maintenance and care of a nonresident
71.5 patient. If the employee worked in a state hospital or nursing home, payment for the care
71.6 shall be made by the commissioner of human services. If employed in any other institution
71.7 or department the payment shall be made from funds allocated or appropriated for the
71.8 operation of the institution or department. If the employee dies from the effects of the disease
71.9 of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of
71.10 death, the workers' compensation division shall order payment to dependents as provided
71.11 for under the general provisions of the workers' compensation law.

71.12 Sec. 97. Minnesota Statutes 2018, section 252A.02, subdivision 12, is amended to read:

71.13 Subd. 12. **Comprehensive evaluation.** "Comprehensive evaluation" shall consist of:

71.14 (1) a medical report on the health status and physical condition of the proposed ward,
71.15 prepared under the direction of a licensed physician or advanced practice registered nurse;

71.16 (2) a report on the proposed ward's intellectual capacity and functional abilities, specifying
71.17 the tests and other data used in reaching its conclusions, prepared by a psychologist who is
71.18 qualified in the diagnosis of developmental disability; and

71.19 (3) a report from the case manager that includes:

71.20 (i) the most current assessment of individual service needs as described in rules of the
71.21 commissioner;

71.22 (ii) the most current individual service plan under section 256B.092, subdivision 1b;
71.23 and

71.24 (iii) a description of contacts with and responses of near relatives of the proposed ward
71.25 notifying them that a nomination for public guardianship has been made and advising them
71.26 that they may seek private guardianship.

71.27 Each report shall contain recommendations as to the amount of assistance and supervision
71.28 required by the proposed ward to function as independently as possible in society. To be
71.29 considered part of the comprehensive evaluation, reports must be completed no more than
71.30 one year before filing the petition under section 252A.05.

72.1 Sec. 98. Minnesota Statutes 2018, section 252A.04, subdivision 2, is amended to read:

72.2 Subd. 2. **Medication; treatment.** A proposed ward who, at the time the comprehensive
72.3 evaluation is to be performed, has been under medical care shall not be so under the influence
72.4 or so suffer the effects of drugs, medication, or other treatment as to be hampered in the
72.5 testing or evaluation process. When in the opinion of the licensed physician or advanced
72.6 practice registered nurse attending the proposed ward, the discontinuance of medication or
72.7 other treatment is not in the proposed ward's best interest, the physician or advanced practice
72.8 registered nurse shall record a list of all drugs, medication or other treatment which the
72.9 proposed ward received 48 hours immediately prior to any examination, test or interview
72.10 conducted in preparation for the comprehensive evaluation.

72.11 Sec. 99. Minnesota Statutes 2018, section 252A.20, subdivision 1, is amended to read:

72.12 Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01
72.13 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and
72.14 mileage prescribed by law; to each physician, advanced practice registered nurse,
72.15 psychologist, or social worker who assists in the preparation of the comprehensive evaluation
72.16 and who is not in the employ of the local agency or the state Department of Human Services,
72.17 a reasonable sum for services and for travel; and to the ward's counsel, when appointed by
72.18 the court, a reasonable sum for travel and for each day or portion of a day actually employed
72.19 in court or actually consumed in preparing for the hearing. Upon order the county auditor
72.20 shall issue a warrant on the county treasurer for payment of the amount allowed.

72.21 Sec. 100. Minnesota Statutes 2018, section 253B.03, subdivision 4, is amended to read:

72.22 Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a
72.23 personal physician or advanced practice registered nurse, spiritual advisor, and counsel at
72.24 all reasonable times. The patient has the right to continue the practice of religion.

72.25 Sec. 101. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

72.26 Subd. 6d. **Adult mental health treatment.** (a) A competent adult may make a declaration
72.27 of preferences or instructions regarding intrusive mental health treatment. These preferences
72.28 or instructions may include, but are not limited to, consent to or refusal of these treatments.

72.29 (b) A declaration may designate a proxy to make decisions about intrusive mental health
72.30 treatment. A proxy designated to make decisions about intrusive mental health treatments
72.31 and who agrees to serve as proxy may make decisions on behalf of a declarant consistent
72.32 with any desires the declarant expresses in the declaration.

73.1 (c) A declaration is effective only if it is signed by the declarant and two witnesses. The
73.2 witnesses must include a statement that they believe the declarant understands the nature
73.3 and significance of the declaration. A declaration becomes operative when it is delivered
73.4 to the declarant's physician, advanced practice registered nurse, or other mental health
73.5 treatment provider. The physician, advanced practice registered nurse, or provider must
73.6 comply with it to the fullest extent possible, consistent with reasonable medical practice,
73.7 the availability of treatments requested, and applicable law. The physician, advanced practice
73.8 registered nurse, or provider shall continue to obtain the declarant's informed consent to all
73.9 intrusive mental health treatment decisions if the declarant is capable of informed consent.
73.10 A treatment provider may not require a person to make a declaration under this subdivision
73.11 as a condition of receiving services.

73.12 (d) The physician, advanced practice registered nurse, or other provider shall make the
73.13 declaration a part of the declarant's medical record. If the physician, advanced practice
73.14 registered nurse, or other provider is unwilling at any time to comply with the declaration,
73.15 the physician, advanced practice registered nurse, or provider must promptly notify the
73.16 declarant and document the notification in the declarant's medical record. If the declarant
73.17 has been committed as a patient under this chapter, the physician, advanced practice
73.18 registered nurse, or provider may subject a declarant to intrusive treatment in a manner
73.19 contrary to the declarant's expressed wishes, only upon order of the committing court. If
73.20 the declarant is not a committed patient under this chapter, the physician, advanced practice
73.21 registered nurse, or provider may subject the declarant to intrusive treatment in a manner
73.22 contrary to the declarant's expressed wishes, only if the declarant is committed as mentally
73.23 ill or mentally ill and dangerous to the public and a court order authorizing the treatment
73.24 has been issued.

73.25 (e) A declaration under this subdivision may be revoked in whole or in part at any time
73.26 and in any manner by the declarant if the declarant is competent at the time of revocation.
73.27 A revocation is effective when a competent declarant communicates the revocation to the
73.28 attending physician, advanced practice registered nurse, or other provider. The attending
73.29 physician, advanced practice registered nurse, or other provider shall note the revocation
73.30 as part of the declarant's medical record.

73.31 (f) A provider who administers intrusive mental health treatment according to and in
73.32 good faith reliance upon the validity of a declaration under this subdivision is held harmless
73.33 from any liability resulting from a subsequent finding of invalidity.

74.1 (g) In addition to making a declaration under this subdivision, a competent adult may
74.2 delegate parental powers under section 524.5-211 or may nominate a guardian under sections
74.3 524.5-101 to 524.5-502.

74.4 Sec. 102. Minnesota Statutes 2018, section 253B.06, subdivision 1, is amended to read:

74.5 Subdivision 1. **Persons who are mentally ill or developmentally disabled.** Every
74.6 patient hospitalized as mentally ill or developmentally disabled pursuant to section 253B.04
74.7 or 253B.05 must be examined by a physician or advanced practice registered nurse as soon
74.8 as possible but no more than 48 hours following admission. The physician or advanced
74.9 practice registered nurse shall be knowledgeable and trained in the diagnosis of the alleged
74.10 disability related to the need for admission as a person who is mentally ill or developmentally
74.11 disabled.

74.12 Sec. 103. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

74.13 Subd. 2. **Chemically dependent persons.** Patients hospitalized as chemically dependent
74.14 pursuant to section 253B.04 or 253B.05 shall also be examined within 48 hours of admission.
74.15 At a minimum, the examination shall consist of a physical evaluation by facility staff
74.16 according to procedures established by a physician or advanced practice registered nurse
74.17 and an evaluation by staff knowledgeable and trained in the diagnosis of the alleged disability
74.18 related to the need for admission as a chemically dependent person.

74.19 Sec. 104. Minnesota Statutes 2018, section 253B.07, subdivision 2, is amended to read:

74.20 Subd. 2. **The petition.** (a) Any interested person, except a member of the prepetition
74.21 screening team, may file a petition for commitment in the district court of the county of
74.22 financial responsibility or the county where the proposed patient is present. If the head of
74.23 the treatment facility believes that commitment is required and no petition has been filed,
74.24 the head of the treatment facility shall petition for the commitment of the person.

74.25 (b) The petition shall set forth the name and address of the proposed patient, the name
74.26 and address of the patient's nearest relatives, and the reasons for the petition. The petition
74.27 must contain factual descriptions of the proposed patient's recent behavior, including a
74.28 description of the behavior, where it occurred, and the time period over which it occurred.
74.29 Each factual allegation must be supported by observations of witnesses named in the petition.
74.30 Petitions shall be stated in behavioral terms and shall not contain judgmental or conclusory
74.31 statements.

75.1 (c) The petition shall be accompanied by a written statement by an examiner stating that
75.2 the examiner has examined the proposed patient within the 15 days preceding the filing of
75.3 the petition and is of the opinion that the proposed patient is suffering a designated disability
75.4 and should be committed to a treatment facility. The statement shall include the reasons for
75.5 the opinion. In the case of a commitment based on mental illness, the petition and the
75.6 examiner's statement shall include, to the extent this information is available, a statement
75.7 and opinion regarding the proposed patient's need for treatment with neuroleptic medication
75.8 and the patient's capacity to make decisions regarding the administration of neuroleptic
75.9 medications, and the reasons for the opinion. If use of neuroleptic medications is
75.10 recommended by the treating physician or advanced practice registered nurse, the petition
75.11 for commitment must, if applicable, include or be accompanied by a request for proceedings
75.12 under section 253B.092. Failure to include the required information regarding neuroleptic
75.13 medications in the examiner's statement, or to include a request for an order regarding
75.14 neuroleptic medications with the commitment petition, is not a basis for dismissing the
75.15 commitment petition. If a petitioner has been unable to secure a statement from an examiner,
75.16 the petition shall include documentation that a reasonable effort has been made to secure
75.17 the supporting statement.

75.18 Sec. 105. Minnesota Statutes 2018, section 253B.08, subdivision 5, is amended to read:

75.19 Subd. 5. **Absence permitted.** (a) The court may permit the proposed patient to waive
75.20 the right to attend the hearing if it determines that the waiver is freely given. At the time of
75.21 the hearing the patient shall not be so under the influence of drugs, medication, or other
75.22 treatment so as to be hampered in participating in the proceedings. When the licensed
75.23 physician, licensed advanced practice registered nurse, or licensed psychologist attending
75.24 the patient is of the opinion that the discontinuance of drugs, medication, or other treatment
75.25 is not in the best interest of the patient, the court, at the time of the hearing, shall be presented
75.26 a record of all drugs, medication or other treatment which the patient has received during
75.27 the 48 hours immediately prior to the hearing.

75.28 (b) The court, on its own motion or on the motion of any party, may exclude or excuse
75.29 a proposed patient who is seriously disruptive or who is incapable of comprehending and
75.30 participating in the proceedings. In such instances, the court shall, with specificity on the
75.31 record, state the behavior of the proposed patient or other circumstances justifying proceeding
75.32 in the absence of the proposed patient.

Sec. 106. Minnesota Statutes 2018, section 253B.092, subdivision 2, is amended to read:

Subd. 2. **Administration without judicial review.** Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care directive under chapter 145C or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) the patient has been prescribed neuroleptic medication prior to admission to a treatment facility, but lacks the capacity to consent to the administration of that neuroleptic medication; continued administration of the medication is in the patient's best interest; and the patient does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating physician or advanced practice registered nurse:

(i) is obtaining a substitute decision-maker appointed by the court under subdivision 6; or

(ii) is requesting an amendment to a current court order authorizing administration of neuroleptic medication;

(4) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

(5) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

Sec. 107. Minnesota Statutes 2018, section 253B.092, subdivision 3, is amended to read:

Subd. 3. **Emergency administration.** A treating physician or advanced practice registered nurse may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating physician or advanced practice registered nurse determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating physician or advanced practice registered nurse may continue

77.1 the medication through the date of the first court hearing, if the emergency continues to
77.2 exist. If the request for authorization to administer medication is made to the court in
77.3 conjunction with a petition for commitment or early intervention and the court makes a
77.4 determination at the preliminary hearing under section 253B.07, subdivision 7, that there
77.5 is sufficient cause to continue the physician's or advanced practice registered nurse's order
77.6 until the hearing under section 253B.08, the treating physician or advanced practice registered
77.7 nurse may continue the medication until that hearing, if the emergency continues to exist.
77.8 The treatment facility shall document the emergency in the patient's medical record in
77.9 specific behavioral terms.

77.10 Sec. 108. Minnesota Statutes 2018, section 253B.092, subdivision 6, is amended to read:

77.11 Subd. 6. **Patients without capacity to make informed decision; substitute**
77.12 **decision-maker.** (a) Upon request of any person, and upon a showing that administration
77.13 of neuroleptic medications may be recommended and that the person may lack capacity to
77.14 make decisions regarding the administration of neuroleptic medication, the court shall
77.15 appoint a substitute decision-maker with authority to consent to the administration of
77.16 neuroleptic medication as provided in this section. A hearing is not required for an
77.17 appointment under this paragraph. The substitute decision-maker must be an individual or
77.18 a community or institutional multidisciplinary panel designated by the local mental health
77.19 authority. In appointing a substitute decision-maker, the court shall give preference to a
77.20 guardian or conservator, proxy, or health care agent with authority to make health care
77.21 decisions for the patient. The court may provide for the payment of a reasonable fee to the
77.22 substitute decision-maker for services under this section or may appoint a volunteer.

77.23 (b) If the person's treating physician or advanced practice registered nurse recommends
77.24 treatment with neuroleptic medication, the substitute decision-maker may give or withhold
77.25 consent to the administration of the medication, based on the standards under subdivision
77.26 7. If the substitute decision-maker gives informed consent to the treatment and the person
77.27 does not refuse, the substitute decision-maker shall provide written consent to the treating
77.28 physician or advanced practice registered nurse and the medication may be administered.
77.29 The substitute decision-maker shall also notify the court that consent has been given. If the
77.30 substitute decision-maker refuses or withdraws consent or the person refuses the medication,
77.31 neuroleptic medication may not be administered to the person without a court order or in
77.32 an emergency.

77.33 (c) A substitute decision-maker appointed under this section has access to the relevant
77.34 sections of the patient's health records on the past or present administration of medication.

78.1 The designated agency or a person involved in the patient's physical or mental health care
78.2 may disclose information to the substitute decision-maker for the sole purpose of performing
78.3 the responsibilities under this section. The substitute decision-maker may not disclose health
78.4 records obtained under this paragraph except to the extent necessary to carry out the duties
78.5 under this section.

78.6 (d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity
78.7 by a preponderance of the evidence. If a substitute decision-maker has been appointed by
78.8 the court, the court shall make findings regarding the patient's capacity to make decisions
78.9 regarding the administration of neuroleptic medications and affirm or reverse its appointment
78.10 of a substitute decision-maker. If the court affirms the appointment of the substitute
78.11 decision-maker, and if the substitute decision-maker has consented to the administration of
78.12 the medication and the patient has not refused, the court shall make findings that the substitute
78.13 decision-maker has consented and the treatment is authorized. If a substitute decision-maker
78.14 has not yet been appointed, upon request the court shall make findings regarding the patient's
78.15 capacity and appoint a substitute decision-maker if appropriate.

78.16 (e) If an order for civil commitment or early intervention did not provide for the
78.17 appointment of a substitute decision-maker or for the administration of neuroleptic
78.18 medication, the treatment facility may later request the appointment of a substitute
78.19 decision-maker upon a showing that administration of neuroleptic medications is
78.20 recommended and that the person lacks capacity to make decisions regarding the
78.21 administration of neuroleptic medications. A hearing is not required in order to administer
78.22 the neuroleptic medication unless requested under subdivision 10 or if the substitute
78.23 decision-maker withholds or refuses consent or the person refuses the medication.

78.24 (f) The substitute decision-maker's authority to consent to treatment lasts for the duration
78.25 of the court's order of appointment or until modified by the court.

78.26 If the substitute decision-maker withdraws consent or the patient refuses consent,
78.27 neuroleptic medication may not be administered without a court order.

78.28 (g) If there is no hearing after the preliminary hearing, then the court shall, upon the
78.29 request of any interested party, review the reasonableness of the substitute decision-maker's
78.30 decision based on the standards under subdivision 7. The court shall enter an order upholding
78.31 or reversing the decision within seven days.

79.1 Sec. 109. Minnesota Statutes 2018, section 253B.092, subdivision 8, is amended to read:

79.2 Subd. 8. **Procedure when patient refuses medication.** (a) If the substitute
79.3 decision-maker or the patient refuses to consent to treatment with neuroleptic medications,
79.4 and absent an emergency as set forth in subdivision 3, neuroleptic medications may not be
79.5 administered without a court order. Upon receiving a written request for a hearing, the court
79.6 shall schedule the hearing within 14 days of the request. The matter may be heard as part
79.7 of any other district court proceeding under this chapter. By agreement of the parties or for
79.8 good cause shown, the court may extend the time of hearing an additional 30 days.

79.9 (b) The patient must be examined by a court examiner prior to the hearing. If the patient
79.10 refuses to participate in an examination, the examiner may rely on the patient's medical
79.11 records to reach an opinion as to the appropriateness of neuroleptic medication. The patient
79.12 is entitled to counsel and a second examiner, if requested by the patient or patient's counsel.

79.13 (c) The court may base its decision on relevant and admissible evidence, including the
79.14 testimony of a treating physician or advanced practice registered nurse or other qualified
79.15 physician, a member of the patient's treatment team, a court-appointed examiner, witness
79.16 testimony, or the patient's medical records.

79.17 (d) If the court finds that the patient has the capacity to decide whether to take neuroleptic
79.18 medication or that the patient lacks capacity to decide and the standards for making a decision
79.19 to administer the medications under subdivision 7 are not met, the treating facility may not
79.20 administer medication without the patient's informed written consent or without the
79.21 declaration of an emergency, or until further review by the court.

79.22 (e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic
79.23 medication and has applied the standards set forth in subdivision 7, the court may authorize
79.24 the treating facility and any other community or treatment facility to which the patient may
79.25 be transferred or provisionally discharged, to involuntarily administer the medication to the
79.26 patient. A copy of the order must be given to the patient, the patient's attorney, the county
79.27 attorney, and the treatment facility. The treatment facility may not begin administration of
79.28 the neuroleptic medication until it notifies the patient of the court's order authorizing the
79.29 treatment.

79.30 (f) A finding of lack of capacity under this section must not be construed to determine
79.31 the patient's competence for any other purpose.

79.32 (g) The court may authorize the administration of neuroleptic medication until the
79.33 termination of a determinate commitment. If the patient is committed for an indeterminate
79.34 period, the court may authorize treatment of neuroleptic medication for not more than two

80.1 years, subject to the patient's right to petition the court for review of the order. The treatment
80.2 facility must submit annual reports to the court, which shall provide copies to the patient
80.3 and the respective attorneys.

80.4 (h) The court may limit the maximum dosage of neuroleptic medication that may be
80.5 administered.

80.6 (i) If physical force is required to administer the neuroleptic medication, force may only
80.7 take place in a treatment facility or therapeutic setting where the person's condition can be
80.8 reassessed and appropriate medical staff are available.

80.9 Sec. 110. Minnesota Statutes 2018, section 253B.0921, is amended to read:

80.10 **253B.0921 ACCESS TO MEDICAL RECORDS.**

80.11 A treating physician or advanced practice registered nurse who makes medical decisions
80.12 regarding the prescription and administration of medication for treatment of a mental illness
80.13 has access to the relevant sections of a patient's health records on past administration of
80.14 medication at any treatment facility, if the patient lacks the capacity to authorize the release
80.15 of records. Upon request of a treating physician or advanced practice registered nurse under
80.16 this section, a treatment facility shall supply complete information relating to the past records
80.17 on administration of medication of a patient subject to this chapter. A patient who has the
80.18 capacity to authorize the release of data retains the right to make decisions regarding access
80.19 to medical records as provided by sections 144.291 to 144.298.

80.20 Sec. 111. Minnesota Statutes 2018, section 253B.20, subdivision 4, is amended to read:

80.21 Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of
80.22 any committed person, the designated agency of the county of financial responsibility, in
80.23 cooperation with the head of the treatment facility, and the patient's physician or advanced
80.24 practice registered nurse, if notified pursuant to subdivision 6, shall establish a continuing
80.25 plan of aftercare services for the patient including a plan for medical and psychiatric
80.26 treatment, nursing care, vocational assistance, and other assistance the patient needs. The
80.27 designated agency shall provide case management services, supervise and assist the patient
80.28 in finding employment, suitable shelter, and adequate medical and psychiatric treatment,
80.29 and aid in the patient's readjustment to the community.

80.30 Sec. 112. Minnesota Statutes 2018, section 253B.20, subdivision 6, is amended to read:

80.31 Subd. 6. **Notice to physician or advanced practice registered nurse.** The head of the
80.32 treatment facility shall notify the physician or advanced practice registered nurse of any

committed person at the time of the patient's discharge or provisional discharge, unless the patient objects to the notice.

Sec. 113. Minnesota Statutes 2018, section 253B.23, subdivision 4, is amended to read:

Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege otherwise existing between patient and physician, patient and advanced practice registered nurse, patient and psychologist, patient and examiner, or patient and social worker, is waived as to any physician, advanced practice registered nurse, psychologist, examiner, or social worker who provides information with respect to a patient pursuant to any provision of this chapter.

Sec. 114. Minnesota Statutes 2018, section 254A.08, subdivision 2, is amended to read:

Subd. 2. **Program requirements.** For the purpose of this section, a detoxification program means a social rehabilitation program licensed by the Department of Human Services under chapter 245A, and governed by the standards of Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and treatment by detoxifying and evaluating the person and providing entrance into a comprehensive program. Evaluation of the person shall include verification by a professional, after preliminary examination, that the person is intoxicated or has symptoms of substance misuse or substance use disorder and appears to be in imminent danger of harming self or others. A detoxification program shall have available the services of a licensed physician or advanced practice registered nurse for medical emergencies and routine medical surveillance. A detoxification program licensed by the Department of Human Services to serve both adults and minors at the same site must provide for separate sleeping areas for adults and minors.

Sec. 115. Minnesota Statutes 2018, section 256.9685, subdivision 1c, is amended to read:

Subd. 1c. **Judicial review.** A hospital ~~or~~, physician, or advanced practice registered nurse aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician, advanced practice registered nurse, or hospital is located by:

82.1 (1) serving a written copy of a notice of appeal upon the commissioner within 30 days
82.2 after the date the commissioner issued the order; and

82.3 (2) filing the original notice of appeal and proof of service with the court administrator
82.4 of the district court. The appeal shall be treated as a dispositive motion under the Minnesota
82.5 General Rules of Practice, rule 115. The district court scope of review shall be as set forth
82.6 in section 14.69.

82.7 Sec. 116. Minnesota Statutes 2018, section 256.975, subdivision 7a, is amended to read:

82.8 Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a)
82.9 All individuals seeking admission to Medicaid-certified nursing facilities, including certified
82.10 boarding care facilities, must be screened prior to admission regardless of income, assets,
82.11 or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs
82.12 (a) and (b). The purpose of the screening is to determine the need for nursing facility level
82.13 of care as described in section 256B.0911, subdivision 4e, and to complete activities required
82.14 under federal law related to mental illness and developmental disability as outlined in
82.15 paragraph (b).

82.16 (b) A person who has a diagnosis or possible diagnosis of mental illness or developmental
82.17 disability must receive a preadmission screening before admission regardless of the
82.18 exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further
82.19 evaluation and specialized services, unless the admission prior to screening is authorized
82.20 by the local mental health authority or the local developmental disabilities case manager,
82.21 or unless authorized by the county agency according to Public Law 101-508.

82.22 (c) The following criteria apply to the preadmission screening:

82.23 (1) requests for preadmission screenings must be submitted via an online form developed
82.24 by the commissioner;

82.25 (2) the Senior LinkAge Line must use forms and criteria developed by the commissioner
82.26 to identify persons who require referral for further evaluation and determination of the need
82.27 for specialized services; and

82.28 (3) the evaluation and determination of the need for specialized services must be done
82.29 by:

82.30 (i) a qualified independent mental health professional, for persons with a primary or
82.31 secondary diagnosis of a serious mental illness; or

83.1 (ii) a qualified developmental disability professional, for persons with a primary or
83.2 secondary diagnosis of developmental disability. For purposes of this requirement, a qualified
83.3 developmental disability professional must meet the standards for a qualified developmental
83.4 disability professional under Code of Federal Regulations, title 42, section 483.430.

83.5 (d) The local county mental health authority or the state developmental disability authority
83.6 under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the
83.7 individual does not meet the nursing facility level of care criteria or needs specialized
83.8 services as defined in Public Laws 100-203 and 101-508. For purposes of this section,
83.9 "specialized services" for a person with developmental disability means active treatment as
83.10 that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

83.11 (e) In assessing a person's needs, the screener shall:

83.12 (1) use an automated system designated by the commissioner;

83.13 (2) consult with care transitions coordinators ~~or~~, physician, or advanced practice registered
83.14 nurse; and

83.15 (3) consider the assessment of the individual's physician or advanced practice registered
83.16 nurse.

83.17 Other personnel may be included in the level of care determination as deemed necessary
83.18 by the screener.

83.19 Sec. 117. Minnesota Statutes 2018, section 256.975, subdivision 11, is amended to read:

83.20 Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging
83.21 shall award competitive grants to eligible applicants for regional and local projects and
83.22 initiatives targeted to a designated community, which may consist of a specific geographic
83.23 area or population, to increase awareness of Alzheimer's disease and other dementias,
83.24 increase the rate of cognitive testing in the population at risk for dementias, promote the
83.25 benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to
83.26 education and resources.

83.27 (b) The project areas for grants include:

83.28 (1) local or community-based initiatives to promote the benefits of physician or advanced
83.29 practice registered nurse consultations for all individuals who suspect a memory or cognitive
83.30 problem;

83.31 (2) local or community-based initiatives to promote the benefits of early diagnosis of
83.32 Alzheimer's disease and other dementias; and

84.1 (3) local or community-based initiatives to provide informational materials and other
84.2 resources to caregivers of persons with dementia.

84.3 (c) Eligible applicants for local and regional grants may include, but are not limited to,
84.4 community health boards, school districts, colleges and universities, community clinics,
84.5 tribal communities, nonprofit organizations, and other health care organizations.

84.6 (d) Applicants must:

84.7 (1) describe the proposed initiative, including the targeted community and how the
84.8 initiative meets the requirements of this subdivision; and

84.9 (2) identify the proposed outcomes of the initiative and the evaluation process to be used
84.10 to measure these outcomes.

84.11 (e) In awarding the regional and local dementia grants, the Minnesota Board on Aging
84.12 must give priority to applicants who demonstrate that the proposed project:

84.13 (1) is supported by and appropriately targeted to the community the applicant serves;

84.14 (2) is designed to coordinate with other community activities related to other health
84.15 initiatives, particularly those initiatives targeted at the elderly;

84.16 (3) is conducted by an applicant able to demonstrate expertise in the project areas;

84.17 (4) utilizes and enhances existing activities and resources or involves innovative
84.18 approaches to achieve success in the project areas; and

84.19 (5) strengthens community relationships and partnerships in order to achieve the project
84.20 areas.

84.21 (f) The board shall divide the state into specific geographic regions and allocate a
84.22 percentage of the money available for the local and regional dementia grants to projects or
84.23 initiatives aimed at each geographic region.

84.24 (g) The board shall award any available grants by January 1, 2016, and each July 1
84.25 thereafter.

84.26 (h) Each grant recipient shall report to the board on the progress of the initiative at least
84.27 once during the grant period, and within two months of the end of the grant period shall
84.28 submit a final report to the board that includes the outcome results.

84.29 (i) The Minnesota Board on Aging shall:

84.30 (1) develop the criteria and procedures to allocate the grants under this subdivision,
84.31 evaluate all applicants on a competitive basis and award the grants, and select qualified

providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training; and

(2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on the dementia grants programs under this subdivision to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over health finance and policy. The report shall include:

(i) information on each grant recipient;

(ii) a summary of all projects or initiatives undertaken with each grant;

(iii) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation; and

(iv) an accounting of how the grant funds were spent.

Sec. 118. Minnesota Statutes 2018, section 256B.04, subdivision 14a, is amended to read:

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician assistant, ~~a nurse practitioner~~ <u>an advanced practice registered nurse</u>, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than annually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

Sec. 119. Minnesota Statutes 2018, section 256B.043, subdivision 2, is amended to read:

Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part of their ongoing duties, shall consider the adequacy of the current system of community health clinics and centers both statewide and in urban areas with significant disparities in health status and access to services across racial and ethnic groups, including:

86.1 (1) methods to provide 24-hour availability of care through the clinics and centers;

86.2 (2) methods to expand the availability of care through the clinics and centers;

86.3 (3) the use of grants to expand the number of clinics and centers, the services provided,
86.4 and the availability of care; and

86.5 (4) the extent to which increased use of physician assistants, ~~nurse practitioners~~ <u>advanced</u>
86.6 <u>practice registered nurses</u>, medical residents and interns, and other allied health professionals
86.7 in clinics and centers would increase the availability of services.

86.8 (b) The commissioners shall make departmental modifications and legislative
86.9 recommendations as appropriate on the basis of their considerations under paragraph (a).

86.10 Sec. 120. Minnesota Statutes 2018, section 256B.055, subdivision 12, is amended to read:

86.11 Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if
86.12 the person is under age 19 and qualifies as a disabled individual under United States Code,
86.13 title 42, section 1382c(a), and would be eligible for medical assistance under the state plan
86.14 if residing in a medical institution, and the child requires a level of care provided in a hospital,
86.15 nursing facility, or intermediate care facility for persons with developmental disabilities,
86.16 for whom home care is appropriate, provided that the cost to medical assistance under this
86.17 section is not more than the amount that medical assistance would pay for if the child resides
86.18 in an institution. After the child is determined to be eligible under this section, the
86.19 commissioner shall review the child's disability under United States Code, title 42, section
86.20 1382c(a) and level of care defined under this section no more often than annually and may
86.21 elect, based on the recommendation of health care professionals under contract with the
86.22 state medical review team, to extend the review of disability and level of care up to a
86.23 maximum of four years. The commissioner's decision on the frequency of continuing review
86.24 of disability and level of care is not subject to administrative appeal under section 256.045.
86.25 The county agency shall send a notice of disability review to the enrollee six months prior
86.26 to the date the recertification of disability is due. Nothing in this subdivision shall be
86.27 construed as affecting other redeterminations of medical assistance eligibility under this
86.28 chapter and annual cost-effective reviews under this section.

86.29 (b) For purposes of this subdivision, "hospital" means an institution as defined in section
86.30 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and
86.31 licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child
86.32 requires a level of care provided in a hospital if the child is determined by the commissioner
86.33 to need an extensive array of health services, including mental health services, for an

87.1 undetermined period of time, whose health condition requires frequent monitoring and
87.2 treatment by a health care professional or by a person supervised by a health care
87.3 professional, who would reside in a hospital or require frequent hospitalization if these
87.4 services were not provided, and the daily care needs are more complex than a nursing facility
87.5 level of care.

87.6 A child with serious emotional disturbance requires a level of care provided in a hospital
87.7 if the commissioner determines that the individual requires 24-hour supervision because
87.8 the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent
87.9 or frequent psychosomatic disorders or somatopsychic disorders that may become life
87.10 threatening, recurrent or frequent severe socially unacceptable behavior associated with
87.11 psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic
87.12 developmental problems requiring continuous skilled observation, or severe disabling
87.13 symptoms for which office-centered outpatient treatment is not adequate, and which overall
87.14 severely impact the individual's ability to function.

87.15 (c) For purposes of this subdivision, "nursing facility" means a facility which provides
87.16 nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections
87.17 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is
87.18 in need of special treatments provided or supervised by a licensed nurse; or has unpredictable
87.19 episodes of active disease processes requiring immediate judgment by a licensed nurse. For
87.20 purposes of this subdivision, a child requires the level of care provided in a nursing facility
87.21 if the child is determined by the commissioner to meet the requirements of the preadmission
87.22 screening assessment document under section 256B.0911, adjusted to address age-appropriate
87.23 standards for children age 18 and under.

87.24 (d) For purposes of this subdivision, "intermediate care facility for persons with
87.25 developmental disabilities" or "ICF/DD" means a program licensed to provide services to
87.26 persons with developmental disabilities under section 252.28, and chapter 245A, and a
87.27 physical plant licensed as a supervised living facility under chapter 144, which together are
87.28 certified by the Minnesota Department of Health as meeting the standards in Code of Federal
87.29 Regulations, title 42, part 483, for an intermediate care facility which provides services for
87.30 persons with developmental disabilities who require 24-hour supervision and active treatment
87.31 for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child
87.32 requires a level of care provided in an ICF/DD if the commissioner finds that the child has
87.33 a developmental disability in accordance with section 256B.092, is in need of a 24-hour
87.34 plan of care and active treatment similar to persons with developmental disabilities, and
87.35 there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians or advanced practice registered nurse or advanced practice registered nurses, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

89.1 Sec. 121. Minnesota Statutes 2018, section 256B.0622, subdivision 2b, is amended to
89.2 read:

89.3 Subd. 2b. **Continuing stay and discharge criteria for assertive community**
89.4 **treatment.** (a) A client receiving assertive community treatment is eligible to continue
89.5 receiving services if:

89.6 (1) the client has not achieved the desired outcomes of their individual treatment plan;

89.7 (2) the client's level of functioning has not been restored, improved, or sustained over
89.8 the time frame outlined in the individual treatment plan;

89.9 (3) the client continues to be at risk for relapse based on current clinical assessment,
89.10 history, or the tenuous nature of the functional gains; or

89.11 (4) the client is functioning effectively with this service and discharge would otherwise
89.12 be indicated but without continued services the client's functioning would decline; and

89.13 (5) one of the following must also apply:

89.14 (i) the client has achieved current individual treatment plan goals but additional goals
89.15 are indicated as evidenced by documented symptoms;

89.16 (ii) the client is making satisfactory progress toward meeting goals and there is
89.17 documentation that supports that continuation of this service shall be effective in addressing
89.18 the goals outlined in the individual treatment plan;

89.19 (iii) the client is making progress, but the specific interventions in the individual treatment
89.20 plan need to be modified so that greater gains, which are consistent with the client's potential
89.21 level of functioning, are possible; or

89.22 (iv) the client fails to make progress or demonstrates regression in meeting goals through
89.23 the interventions outlined in the individual treatment plan.

89.24 (b) Clients receiving assertive community treatment are eligible to be discharged if they
89.25 meet at least one of the following criteria:

89.26 (1) the client and the ACT team determine that assertive community treatment services
89.27 are no longer needed based on the attainment of goals as identified in the individual treatment
89.28 plan and a less intensive level of care would adequately address current goals;

89.29 (2) the client moves out of the ACT team's service area and the ACT team has facilitated
89.30 the referral to either a new ACT team or other appropriate mental health service and has
89.31 assisted the individual in the transition process;

90.1 (3) the client, or the client's legal guardian when applicable, chooses to withdraw from
90.2 assertive community treatment services and documented attempts by the ACT team to
90.3 re-engage the client with the service have not been successful;

90.4 (4) the client has a demonstrated need for a medical nursing home placement lasting
90.5 more than three months, as determined by a physician or advanced practice registered nurse;

90.6 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
90.7 than three months. However, the ACT team must make provisions for the client to return
90.8 to the ACT team upon their discharge or release from the hospital or jail if the client still
90.9 meets eligibility criteria for assertive community treatment and the team is not at full capacity;

90.10 (6) the ACT team is unable to locate, contact, and engage the client for a period of greater
90.11 than three months after persistent efforts by the ACT team to locate the client; or

90.12 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
90.13 team to engage the client in service planning. The ACT team must develop a transition plan
90.14 to arrange for alternate treatment for clients in this situation who have a history of suicide
90.15 attempts, assault, or forensic involvement.

90.16 (c) For all clients who are discharged from assertive community treatment to another
90.17 service provider within the ACT team's service area there is a three-month transfer period,
90.18 from the date of discharge, during which a client who does not adjust well to the new service,
90.19 may voluntarily return to the ACT team. During this period, the ACT team must maintain
90.20 contact with the client's new service provider.

90.21 Sec. 122. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

90.22 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
90.23 given them.

90.24 (a) "Adult rehabilitative mental health services" means mental health services which are
90.25 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
90.26 competencies, personal and emotional adjustment, independent living, parenting skills, and
90.27 community skills, when these abilities are impaired by the symptoms of mental illness.
90.28 Adult rehabilitative mental health services are also appropriate when provided to enable a
90.29 recipient to retain stability and functioning, if the recipient would be at risk of significant
90.30 functional decompensation or more restrictive service settings without these services.

90.31 (1) Adult rehabilitative mental health services instruct, assist, and support the recipient
90.32 in areas such as: interpersonal communication skills, community resource utilization and
90.33 integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting

91.1 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
91.2 transportation skills, medication education and monitoring, mental illness symptom
91.3 management skills, household management skills, employment-related skills, parenting
91.4 skills, and transition to community living services.

91.5 (2) These services shall be provided to the recipient on a one-to-one basis in the recipient's
91.6 home or another community setting or in groups.

91.7 (b) "Medication education services" means services provided individually or in groups
91.8 which focus on educating the recipient about mental illness and symptoms; the role and
91.9 effects of medications in treating symptoms of mental illness; and the side effects of
91.10 medications. Medication education is coordinated with medication management services
91.11 and does not duplicate it. Medication education services are provided by physicians, advanced
91.12 practice registered nurses, pharmacists, physician assistants, or registered nurses.

91.13 (c) "Transition to community living services" means services which maintain continuity
91.14 of contact between the rehabilitation services provider and the recipient and which facilitate
91.15 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
91.16 9505, board and lodging facility, or nursing home. Transition to community living services
91.17 are not intended to provide other areas of adult rehabilitative mental health services.

91.18 Sec. 123. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to
91.19 read:

91.20 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers
91.21 eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed
91.22 practitioner.

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

91.25 Sec. 124. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is
91.26 amended to read:

91.27 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
91.28 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
91.29 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
91.30 dispensing physician, or by a physician, a physician assistant, or ~~a nurse practitioner~~ an
91.31 advanced practice registered nurse employed by or under contract with a community health

92.1 board as defined in section 145A.02, subdivision 5, for the purposes of communicable
92.2 disease control.

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

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

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

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

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

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

92.33 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
92.34 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and

93.1 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
93.2 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
93.3 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
93.4 individuals, medical assistance may cover drugs from the drug classes listed in United States
93.5 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
93.6 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
93.7 not be covered.

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

93.12 Sec. 125. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is
93.13 amended to read:

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

93.18 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
93.19 emergency medical care or transportation costs incurred by eligible persons in obtaining
93.20 emergency or nonemergency medical care when paid directly to an ambulance company,
93.21 nonemergency medical transportation company, or other recognized providers of
93.22 transportation services. Medical transportation must be provided by:

93.23 (1) nonemergency medical transportation providers who meet the requirements of this
93.24 subdivision;

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

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

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

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

93.29 (c) Medical assistance covers nonemergency medical transportation provided by
93.30 nonemergency medical transportation providers enrolled in the Minnesota health care
93.31 programs. All nonemergency medical transportation providers must comply with the
93.32 operating standards for special transportation service as defined in sections 174.29 to 174.30

94.1 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
94.2 commissioner and reported on the claim as the individual who provided the service. All
94.3 nonemergency medical transportation providers shall bill for nonemergency medical
94.4 transportation services in accordance with Minnesota health care programs criteria. Publicly
94.5 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
94.6 requirements outlined in this paragraph.

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

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

94.10 (2) the provider has initiated background studies on the individuals specified in section
94.11 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

94.31 (g) The commissioner may use an order by the recipient's attending physician, advanced
94.32 practice registered nurse, or a medical or mental health professional to certify that the

95.1 recipient requires nonemergency medical transportation services. Nonemergency medical
95.2 transportation providers shall perform driver-assisted services for eligible individuals, when
95.3 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
95.4 residence or place of business, assistance with admittance of the individual to the medical
95.5 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
95.6 or stretchers in the vehicle.

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

95.11 Nonemergency medical transportation providers may not bill for separate base rates for
95.12 the continuation of a trip beyond the original destination. Nonemergency medical
95.13 transportation providers must maintain trip logs, which include pickup and drop-off times,
95.14 signed by the medical provider or client, whichever is deemed most appropriate, attesting
95.15 to mileage traveled to obtain covered medical services. Clients requesting client mileage
95.16 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
95.17 services.

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

95.23 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

96.17 (k) The commissioner shall:

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

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

96.21 (3) investigate all complaints and appeals.

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

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

96.31 (1) $0.22 per mile for client reimbursement;

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

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

97.6 (4) $13 for the base rate and $1.30 per mile for assisted transport;

97.7 (5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

97.8 (6) $75 for the base rate and $2.40 per mile for protected transport; and

97.9 (7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for
97.10 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

97.28 Sec. 126. Minnesota Statutes 2018, section 256B.0625, subdivision 26, is amended to
97.29 read:

97.30 Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary
97.31 in making a determination for eligibility for individualized education program and

98.1 individualized family service plan services and for medical services identified in a recipient's
98.2 individualized education program and individualized family service plan and covered under
98.3 the medical assistance state plan. Covered services include occupational therapy, physical
98.4 therapy, speech-language therapy, clinical psychological services, nursing services, school
98.5 psychological services, school social work services, personal care assistants serving as
98.6 management aides, assistive technology devices, transportation services, health assessments,
98.7 and other services covered under the medical assistance state plan. Mental health services
98.8 eligible for medical assistance reimbursement must be provided or coordinated through a
98.9 children's mental health collaborative where a collaborative exists if the child is included
98.10 in the collaborative operational target population. The provision or coordination of services
98.11 does not require that the individualized education program be developed by the collaborative.

98.12 The services may be provided by a Minnesota school district that is enrolled as a medical
98.13 assistance provider or its subcontractor, and only if the services meet all the requirements
98.14 otherwise applicable if the service had been provided by a provider other than a school
98.15 district, in the following areas: medical necessity, physician's or advanced practice registered
98.16 nurse's orders, documentation, personnel qualifications, and prior authorization requirements.
98.17 The nonfederal share of costs for services provided under this subdivision is the responsibility
98.18 of the local school district as provided in section 125A.74. Services listed in a child's
98.19 individualized education program are eligible for medical assistance reimbursement only
98.20 if those services meet criteria for federal financial participation under the Medicaid program.

98.21 (b) Approval of health-related services for inclusion in the individualized education
98.22 program does not require prior authorization for purposes of reimbursement under this
98.23 chapter. The commissioner may require physician or advanced practice registered nurse
98.24 review and approval of the plan not more than once annually or upon any modification of
98.25 the individualized education program that reflects a change in health-related services.

98.26 (c) Services of a speech-language pathologist provided under this section are covered
98.27 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

98.28 (1) holds a masters degree in speech-language pathology;

98.29 (2) is licensed by the Professional Educator Licensing and Standards Board as an
98.30 educational speech-language pathologist; and

98.31 (3) either has a certificate of clinical competence from the American Speech and Hearing
98.32 Association, has completed the equivalent educational requirements and work experience
98.33 necessary for the certificate or has completed the academic program and is acquiring
98.34 supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individualized education program or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Sec. 127. Minnesota Statutes 2018, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. **~~Certified nurse practitioner~~ Advanced practice registered nurse services.** Medical assistance covers services performed by a certified pediatric ~~nurse practitioner~~ advanced practice registered nurse, a certified family ~~nurse practitioner~~ advanced practice registered nurse, a certified adult ~~nurse practitioner~~ advanced practice registered

nurse, a certified obstetric/gynecological ~~nurse practitioner~~ advanced practice registered nurse, a certified neonatal ~~nurse practitioner~~ advanced practice registered nurse, or a certified geriatric ~~nurse practitioner~~ advanced practice registered nurse in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the ~~nurse practitioner's~~ advanced practice registered nurse's license as a registered nurse, as defined in section 148.171.

Sec. 128. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is amended to read:

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

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

(1) verbal or visual reminders of discharge orders;

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

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

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

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

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

101.3 Sec. 129. Minnesota Statutes 2018, section 256B.0654, subdivision 1, is amended to read:

101.4 Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing
101.5 services provided to recipients who meet the criteria for regular home care nursing and
101.6 require life-sustaining interventions to reduce the risk of long-term injury or death.

101.7 (b) "Home care nursing" means ongoing ~~physician-ordered~~ hourly nursing ordered by
101.8 a physician or advanced practice registered nurse and services performed by a registered
101.9 nurse or licensed practical nurse within the scope of practice as defined by the Minnesota
101.10 Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a
101.11 person's health.

101.12 (c) "Home care nursing agency" means a medical assistance enrolled provider licensed
101.13 under chapter 144A to provide home care nursing services.

101.14 (d) "Regular home care nursing" means home care nursing provided because:

101.15 (1) the recipient requires more individual and continuous care than can be provided
101.16 during a skilled nurse visit; or

101.17 (2) the cares are outside of the scope of services that can be provided by a home health
101.18 aide or personal care assistant.

101.19 (e) "Shared home care nursing" means the provision of home care nursing services by
101.20 a home care nurse to two recipients at the same time and in the same setting.

101.21 Sec. 130. Minnesota Statutes 2018, section 256B.0654, subdivision 2a, is amended to
101.22 read:

101.23 Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

101.24 (1) in the recipient's home or outside the home when normal life activities require;

101.25 (2) when the recipient requires more individual and continuous care than can be provided
101.26 during a skilled nurse visit; and

101.27 (3) when the care required is outside of the scope of services that can be provided by a
101.28 home health aide or personal care assistant.

101.29 (b) Home care nursing services must be:

101.30 (1) assessed by a registered nurse on a form approved by the commissioner;

102.1 (2) ordered by a physician or advanced practice registered nurse and documented in a
102.2 plan of care that is reviewed by the physician at least once every 60 days; and

102.3 (3) authorized by the commissioner under section 256B.0652.

102.4 Sec. 131. Minnesota Statutes 2018, section 256B.0654, subdivision 3, is amended to read:

102.5 Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared
102.6 home care nursing services by a home care nurse shall be limited according to this
102.7 subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory
102.8 provisions relating to home care nursing services apply to shared home care nursing services.
102.9 Nothing in this subdivision shall be construed to reduce the total number of home care
102.10 nursing hours authorized for an individual recipient.

102.11 (b) Shared home care nursing is the provision of nursing services by a home care nurse
102.12 to two medical assistance eligible recipients at the same time and in the same setting. This
102.13 subdivision does not apply when a home care nurse is caring for multiple recipients in more
102.14 than one setting.

102.15 (c) For the purposes of this subdivision, "setting" means:

102.16 (1) the home residence or foster care home of one of the individual recipients as defined
102.17 in section 256B.0651;

102.18 (2) a child care program licensed under chapter 245A or operated by a local school
102.19 district or private school;

102.20 (3) an adult day care service licensed under chapter 245A; or

102.21 (4) outside the home residence or foster care home of one of the recipients when normal
102.22 life activities take the recipients outside the home.

102.23 (d) The home care nursing agency must offer the recipient the option of shared or
102.24 one-on-one home care nursing services. The recipient may withdraw from participating in
102.25 a shared service arrangement at any time.

102.26 (e) The recipient or the recipient's legal representative, and the recipient's physician or
102.27 advanced practice registered nurse, in conjunction with the home care nursing agency, shall
102.28 determine:

102.29 (1) whether shared home care nursing care is an appropriate option based on the individual
102.30 needs and preferences of the recipient; and

103.1 (2) the amount of shared home care nursing services authorized as part of the overall
103.2 authorization of nursing services.

103.3 (f) The recipient or the recipient's legal representative, in conjunction with the home
103.4 care nursing agency, shall approve the setting, grouping, and arrangement of shared home
103.5 care nursing care based on the individual needs and preferences of the recipients. Decisions
103.6 on the selection of recipients to share services must be based on the ages of the recipients,
103.7 compatibility, and coordination of their care needs.

103.8 (g) The following items must be considered by the recipient or the recipient's legal
103.9 representative and the home care nursing agency, and documented in the recipient's health
103.10 service record:

103.11 (1) the additional training needed by the home care nurse to provide care to two recipients
103.12 in the same setting and to ensure that the needs of the recipients are met appropriately and
103.13 safely;

103.14 (2) the setting in which the shared home care nursing care will be provided;

103.15 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of
103.16 the service and process used to make changes in service or setting;

103.17 (4) a contingency plan which accounts for absence of the recipient in a shared home
103.18 care nursing setting due to illness or other circumstances;

103.19 (5) staffing backup contingencies in the event of employee illness or absence; and

103.20 (6) arrangements for additional assistance to respond to urgent or emergency care needs
103.21 of the recipients.

103.22 (h) The documentation for shared home care nursing must be on a form approved by
103.23 the commissioner for each individual recipient sharing home care nursing. The documentation
103.24 must be part of the recipient's health service record and include:

103.25 (1) permission by the recipient or the recipient's legal representative for the maximum
103.26 number of shared nursing hours per week chosen by the recipient and permission for shared
103.27 home care nursing services provided in and outside the recipient's home residence;

103.28 (2) revocation by the recipient or the recipient's legal representative for the shared home
103.29 care nursing permission, or services provided to others in and outside the recipient's
103.30 residence; and

103.31 (3) daily documentation of the shared home care nursing services provided by each
103.32 identified home care nurse, including:

104.1 (i) the names of each recipient receiving shared home care nursing services;

104.2 (ii) the setting for the shared services, including the starting and ending times that the
104.3 recipient received shared home care nursing care; and

104.4 (iii) notes by the home care nurse regarding changes in the recipient's condition, problems
104.5 that may arise from the sharing of home care nursing services, and scheduling and care
104.6 issues.

104.7 (i) The commissioner shall provide a rate methodology for shared home care nursing.
104.8 For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times
104.9 the regular home care nursing rates paid for serving a single individual by a registered nurse
104.10 or licensed practical nurse. These rates apply only to situations in which both recipients are
104.11 present and receive shared home care nursing care on the date for which the service is billed.

104.12 Sec. 132. Minnesota Statutes 2018, section 256B.0654, subdivision 4, is amended to read:

104.13 Subd. 4. **Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary
104.14 services that require specialized nursing skills and are provided by parents of minor children,
104.15 family foster parents, spouses, and legal guardians who are providing home care nursing
104.16 care under the following conditions:

104.17 (1) the provision of these services is not legally required of the parents, spouses, or legal
104.18 guardians;

104.19 (2) the services are necessary to prevent hospitalization of the recipient; and

104.20 (3) the recipient is eligible for state plan home care or a home and community-based
104.21 waiver and one of the following hardship criteria are met:

104.22 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
104.23 provide nursing care for the recipient;

104.24 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
104.25 less compensation to provide nursing care for the recipient;

104.26 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide
104.27 nursing care for the recipient; or

104.28 (iv) because of labor conditions, special language needs, or intermittent hours of care
104.29 needed, the parent, spouse, or legal guardian is needed in order to provide adequate home
104.30 care nursing services to meet the medical needs of the recipient.

105.1 (b) Home care nursing may be provided by a parent, spouse, family foster parent, or
105.2 legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided
105.3 by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing
105.4 services covered and available under liable third-party payors, including Medicare. The
105.5 home care nursing provided by a parent, spouse, family foster parent, or legal guardian must
105.6 be included in the service agreement. Authorized nursing services for a single recipient or
105.7 recipients with the same residence and provided by the parent, spouse, family foster parent,
105.8 or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight
105.9 hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents,
105.10 spouse, family foster parent, or legal guardian shall not provide more than 40 hours of
105.11 services in a seven-day period. For parents, family foster parents, and legal guardians, 40
105.12 hours is the total amount allowed regardless of the number of children or adults who receive
105.13 services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's
105.14 obligation of assuming the nonreimbursed family responsibilities of emergency backup
105.15 caregiver and primary caregiver.

105.16 (c) A parent, family foster parent, or a spouse may not be paid to provide home care
105.17 nursing care if:

105.18 (1) the parent or spouse fails to pass a criminal background check according to chapter
105.19 245C;

105.20 (2) it has been determined by the home care nursing agency, the case manager, or the
105.21 physician or advanced practice registered nurse that the home care nursing provided by the
105.22 parent, family foster parent, spouse, or legal guardian is unsafe; or

105.23 (3) the parent, family foster parent, spouse, or legal guardian does not follow physician
105.24 or advanced practice registered nurse orders.

105.25 (d) For purposes of this section, "assessment" means a review and evaluation of a
105.26 recipient's need for home care services conducted in person. Assessments for home care
105.27 nursing must be conducted by a registered nurse.

105.28 Sec. 133. Minnesota Statutes 2018, section 256B.0659, subdivision 2, is amended to read:

105.29 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
105.30 assistance services eligible for payment include services and supports furnished to an
105.31 individual, as needed, to assist in:

105.32 (1) activities of daily living;

105.33 (2) health-related procedures and tasks;

106.1 (3) observation and redirection of behaviors; and

106.2 (4) instrumental activities of daily living.

106.3 (b) Activities of daily living include the following covered services:

106.4 (1) dressing, including assistance with choosing, application, and changing of clothing
106.5 and application of special appliances, wraps, or clothing;

106.6 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
106.7 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
106.8 except for recipients who are diabetic or have poor circulation;

106.9 (3) bathing, including assistance with basic personal hygiene and skin care;

106.10 (4) eating, including assistance with hand washing and application of orthotics required
106.11 for eating, transfers, and feeding;

106.12 (5) transfers, including assistance with transferring the recipient from one seating or
106.13 reclining area to another;

106.14 (6) mobility, including assistance with ambulation, including use of a wheelchair.
106.15 Mobility does not include providing transportation for a recipient;

106.16 (7) positioning, including assistance with positioning or turning a recipient for necessary
106.17 care and comfort; and

106.18 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
106.19 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
106.20 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
106.21 clothing.

106.22 (c) Health-related procedures and tasks include the following covered services:

106.23 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
106.24 functioning;

106.25 (2) assistance with self-administered medication as defined by this section, including
106.26 reminders to take medication, bringing medication to the recipient, and assistance with
106.27 opening medication under the direction of the recipient or responsible party, including
106.28 medications given through a nebulizer;

106.29 (3) interventions for seizure disorders, including monitoring and observation; and

106.30 (4) other activities considered within the scope of the personal care service and meeting
106.31 the definition of health-related procedures and tasks under this section.

107.1 (d) A personal care assistant may provide health-related procedures and tasks associated
107.2 with the complex health-related needs of a recipient if the procedures and tasks meet the
107.3 definition of health-related procedures and tasks under this section and the personal care
107.4 assistant is trained by a qualified professional and demonstrates competency to safely
107.5 complete the procedures and tasks. Delegation of health-related procedures and tasks and
107.6 all training must be documented in the personal care assistance care plan and the recipient's
107.7 and personal care assistant's files. A personal care assistant must not determine the medication
107.8 dose or time for medication.

107.9 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
107.10 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
107.11 support there must be:

107.12 (1) delegation and training by a registered nurse<u>, advanced practice registered nurse,</u>
107.13 certified or licensed respiratory therapist, or a physician;

107.14 (2) utilization of clean rather than sterile procedure;

107.15 (3) specialized training about the health-related procedures and tasks and equipment,
107.16 including ventilator operation and maintenance;

107.17 (4) individualized training regarding the needs of the recipient; and

107.18 (5) supervision by a qualified professional who is a registered nurse.

107.19 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
107.20 recipient for episodes where there is a need for redirection due to behaviors. Training of
107.21 the personal care assistant must occur based on the needs of the recipient, the personal care
107.22 assistance care plan, and any other support services provided.

107.23 (g) Instrumental activities of daily living under subdivision 1, paragraph (i).

107.24 Sec. 134. Minnesota Statutes 2018, section 256B.0659, subdivision 4, is amended to read:

107.25 Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An
107.26 assessment as defined in subdivision 3a must be completed for personal care assistance
107.27 services.

107.28 (b) The following limitations apply to the assessment:

107.29 (1) a person must be assessed as dependent in an activity of daily living based on the
107.30 person's daily need or need on the days during the week the activity is completed for:

107.31 (i) cuing and constant supervision to complete the task; or

108.1 (ii) hands-on assistance to complete the task; and

108.2 (2) a child may not be found to be dependent in an activity of daily living if because of
108.3 the child's age an adult would either perform the activity for the child or assist the child
108.4 with the activity. Assistance needed is the assistance appropriate for a typical child of the
108.5 same age.

108.6 (c) Assessment for complex health-related needs must meet the criteria in this paragraph.
108.7 A recipient qualifies as having complex health-related needs if the recipient has one or more
108.8 of the interventions that are ordered by a physician or advanced practice registered nurse,
108.9 specified in a personal care assistance care plan or community support plan developed under
108.10 section 256B.0911, and found in the following:

108.11 (1) tube feedings requiring:

108.12 (i) a gastrojejunostomy tube; or

108.13 (ii) continuous tube feeding lasting longer than 12 hours per day;

108.14 (2) wounds described as:

108.15 (i) stage III or stage IV;

108.16 (ii) multiple wounds;

108.17 (iii) requiring sterile or clean dressing changes or a wound vac; or

108.18 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
108.19 care;

108.20 (3) parenteral therapy described as:

108.21 (i) IV therapy more than two times per week lasting longer than four hours for each
108.22 treatment; or

108.23 (ii) total parenteral nutrition (TPN) daily;

108.24 (4) respiratory interventions, including:

108.25 (i) oxygen required more than eight hours per day;

108.26 (ii) respiratory vest more than one time per day;

108.27 (iii) bronchial drainage treatments more than two times per day;

108.28 (iv) sterile or clean suctioning more than six times per day;

108.29 (v) dependence on another to apply respiratory ventilation augmentation devices such
108.30 as BiPAP and CPAP; and

109.1 (vi) ventilator dependence under section 256B.0652;

109.2 (5) insertion and maintenance of catheter, including:

109.3 (i) sterile catheter changes more than one time per month;

109.4 (ii) clean intermittent catheterization, and including self-catheterization more than six
109.5 times per day; or

109.6 (iii) bladder irrigations;

109.7 (6) bowel program more than two times per week requiring more than 30 minutes to
109.8 perform each time;

109.9 (7) neurological intervention, including:

109.10 (i) seizures more than two times per week and requiring significant physical assistance
109.11 to maintain safety; or

109.12 (ii) swallowing disorders diagnosed by a physician or advanced practice registered nurse
109.13 and requiring specialized assistance from another on a daily basis; and

109.14 (8) other congenital or acquired diseases creating a need for significantly increased direct
109.15 hands-on assistance and interventions in six to eight activities of daily living.

109.16 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
109.17 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
109.18 assistance at least four times per week and shows one or more of the following behaviors:

109.19 (1) physical aggression towards self or others, or destruction of property that requires
109.20 the immediate response of another person;

109.21 (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
109.22 or

109.23 (3) increased need for assistance for recipients who are verbally aggressive or resistive
109.24 to care so that the time needed to perform activities of daily living is increased.

109.25 Sec. 135. Minnesota Statutes 2018, section 256B.0659, subdivision 8, is amended to read:

109.26 Subd. 8. **Communication with recipient's physician or advanced practice registered**
109.27 **nurse.** The personal care assistance program requires communication with the recipient's
109.28 physician or advanced practice registered nurse about a recipient's assessed needs for personal
109.29 care assistance services. The commissioner shall work with the state medical director to
109.30 develop options for communication with the recipient's physician or advanced practice
109.31 registered nurse.

Sec. 136. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components:

111.1 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
111.2 roles and responsibilities of personal care assistants including information about assistance
111.3 with lifting and transfers for recipients, emergency preparedness, orientation to positive
111.4 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
111.5 training components, the personal care assistant must demonstrate the competency to provide
111.6 assistance to recipients;

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

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

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

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

111.18 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
111.19 17a if the personal care assistant providing the services:

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

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

111.26 Sec. 137. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is
111.27 amended to read:

111.28 Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The
111.29 case manager shall implement the coordinated service and support plan for each alternative
111.30 care client and ensure that a client's service needs and eligibility are reassessed at least every
111.31 12 months. The coordinated service and support plan must meet the requirements in section
111.32 256S.10. The plan shall include any services prescribed by the individual's attending
111.33 physician or advanced practice registered nurse as necessary to allow the individual to

112.1 remain in a community setting. In developing the individual's care plan, the case manager
112.2 should include the use of volunteers from families and neighbors, religious organizations,
112.3 social clubs, and civic and service organizations to support the formal home care services.
112.4 The lead agency shall be held harmless for damages or injuries sustained through the use
112.5 of volunteers under this subdivision including workers' compensation liability. The case
112.6 manager shall provide documentation in each individual's plan and, if requested, to the
112.7 commissioner that the most cost-effective alternatives available have been offered to the
112.8 individual and that the individual was free to choose among available qualified providers,
112.9 both public and private, including qualified case management or service coordination
112.10 providers other than those employed by any county; however, the county or tribe maintains
112.11 responsibility for prior authorizing services in accordance with statutory and administrative
112.12 requirements. The case manager must give the individual a ten-day written notice of any
112.13 denial, termination, or reduction of alternative care services.

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

112.19 Sec. 138. Minnesota Statutes 2018, section 256B.73, subdivision 5, is amended to read:

112.20 Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider
112.21 shall receive a health services benefit package that includes health services which the
112.22 enrollees might reasonably require to be maintained in good health, including emergency
112.23 care, inpatient hospital and physician or advanced practice registered nurse care, outpatient
112.24 health services, and preventive health services.

112.25 (b) Services related to chemical dependency, mental illness, vision care, dental care,
112.26 and other benefits may be excluded or limited upon approval by the commissioners. The
112.27 coalition may petition the commissioner of commerce or health, whichever is appropriate,
112.28 for waivers that allow these benefits to be excluded or limited.

112.29 (c) The commissioners, the coalition, and demonstration providers shall work together
112.30 to design a package of benefits or packages of benefits that can be provided to enrollees for
112.31 an affordable monthly premium.

113.1 Sec. 139. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:

113.2 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a
113.3 "qualified professional" means a licensed physician, a physician assistant, ~~a nurse practitioner~~
113.4 an advanced practice registered nurse, or a licensed chiropractor.

113.5 (b) For developmental disability and intelligence testing, a "qualified professional"
113.6 means an individual qualified by training and experience to administer the tests necessary
113.7 to make determinations, such as tests of intellectual functioning, assessments of adaptive
113.8 behavior, adaptive skills, and developmental functioning. These professionals include
113.9 licensed psychologists, certified school psychologists, or certified psychometrists working
113.10 under the supervision of a licensed psychologist.

113.11 (c) For learning disabilities, a "qualified professional" means a licensed psychologist or
113.12 school psychologist with experience determining learning disabilities.

113.13 (d) For mental health, a "qualified professional" means a licensed physician or a qualified
113.14 mental health professional. A "qualified mental health professional" means:

113.15 (1) for children, in psychiatric nursing, a registered nurse or advanced practice registered
113.16 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
113.17 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
113.18 certification organization or who has a master's degree in nursing or one of the behavioral
113.19 sciences or related fields from an accredited college or university or its equivalent, with at
113.20 least 4,000 hours of post-master's supervised experience in the delivery of clinical services
113.21 in the treatment of mental illness;

113.22 (2) for adults, in psychiatric nursing, a registered nurse or advanced practice registered
113.23 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
113.24 specialist in adult psychiatric and mental health nursing by a national nurse certification
113.25 organization or who has a master's degree in nursing or one of the behavioral sciences or
113.26 related fields from an accredited college or university or its equivalent, with at least 4,000
113.27 hours of post-master's supervised experience in the delivery of clinical services in the
113.28 treatment of mental illness;

113.29 (3) in clinical social work, a person licensed as an independent clinical social worker
113.30 under chapter 148D, or a person with a master's degree in social work from an accredited
113.31 college or university, with at least 4,000 hours of post-master's supervised experience in
113.32 the delivery of clinical services in the treatment of mental illness;

114.1 (4) in psychology, an individual licensed by the Board of Psychology under sections
114.2 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis
114.3 and treatment of mental illness;

114.4 (5) in psychiatry, a physician licensed under chapter 147 and certified by the American
114.5 Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

114.6 (6) in marriage and family therapy, the mental health professional must be a marriage
114.7 and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of
114.8 post-master's supervised experience in the delivery of clinical services in the treatment of
114.9 mental illness; and

114.10 (7) in licensed professional clinical counseling, the mental health professional shall be
114.11 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours
114.12 of post-master's supervised experience in the delivery of clinical services in the treatment
114.13 of mental illness.

114.14 Sec. 140. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

114.15 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
114.16 **NECESSITY.**

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

114.24 (b) For a nursing facility with a total property payment rate determined under section
114.25 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established
114.26 total payment rate for a resident if the resident is a medical assistance recipient and the
114.27 private room is considered a medical necessity for the resident or others who are affected
114.28 by the resident's condition. Conditions requiring a private room must be determined by the
114.29 resident's attending physician and submitted to the commissioner for approval or denial by
114.30 the commissioner on the basis of medical necessity.

115.1 Sec. 141. Minnesota Statutes 2018, section 256R.54, subdivision 1, is amended to read:

115.2 Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The
115.3 commissioner shall adopt rules under the Administrative Procedure Act to set the amount
115.4 and method of payment for ancillary materials and services provided to recipients residing
115.5 in nursing facilities. Payment for materials and services may be made to either the vendor
115.6 of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a
115.7 nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

115.8 (b) Payment for the same or similar service to a recipient shall not be made to both the
115.9 nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double
115.10 payments through audits and adjustments to the nursing facility's annual cost report as
115.11 required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements
115.12 for ancillary materials and services are cost-effective and as would be incurred by a prudent
115.13 and cost-conscious buyer.

115.14 (c) Therapy services provided to a recipient must be medically necessary and appropriate
115.15 to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician
115.16 or advanced practice registered nurse cannot provide adequate medical necessity justification,
115.17 as determined by the commissioner, the commissioner may recover or disallow the payment
115.18 for the services and may require prior authorization for therapy services as a condition of
115.19 payment or may impose administrative sanctions to limit the vendor, nursing facility, or
115.20 ordering physician's or advanced practice registered nurse's participation in the medical
115.21 assistance program. If the provider number of a nursing facility is used to bill services
115.22 provided by a vendor of therapy services that is not related to the nursing facility by
115.23 ownership, control, affiliation, or employment status, no withholding of payment shall be
115.24 imposed against the nursing facility for services not medically necessary except for funds
115.25 due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose
115.26 of this subdivision, no monetary recovery may be imposed against the nursing facility for
115.27 funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for
115.28 services not medically necessary.

115.29 (d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy
115.30 includes physical therapy, occupational therapy, speech therapy, audiology, and mental
115.31 health services that are covered services according to Minnesota Rules, parts 9505.0170 to
115.32 9505.0475.

115.33 (e) For purposes of this subdivision, "ancillary services" includes transportation defined
115.34 as a covered service in section 256B.0625, subdivision 17.

116.1 Sec. 142. Minnesota Statutes 2018, section 256R.54, subdivision 2, is amended to read:

116.2 Subd. 2. **Certification that treatment is appropriate.** The physical therapist,
116.3 occupational therapist, speech therapist, mental health professional, or audiologist who
116.4 provides or supervises the provision of therapy services, other than an initial evaluation, to
116.5 a medical assistance recipient must certify in writing that the therapy's nature, scope, duration,
116.6 and intensity are appropriate to the medical condition of the recipient every 30 days. The
116.7 therapist's statement of certification must be maintained in the recipient's medical record
116.8 together with the specific orders by the physician or advanced practice registered nurse and
116.9 the treatment plan. If the recipient's medical record does not include these documents, the
116.10 commissioner may recover or disallow the payment for such services. If the therapist
116.11 determines that the therapy's nature, scope, duration, or intensity is not appropriate to the
116.12 medical condition of the recipient, the therapist must provide a statement to that effect in
116.13 writing to the nursing facility for inclusion in the recipient's medical record. The
116.14 commissioner shall make recommendations regarding the medical necessity of services
116.15 provided.

116.16 Sec. 143. Minnesota Statutes 2018, section 257.63, subdivision 3, is amended to read:

116.17 Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered
116.18 nurse concerning the medical circumstances of the pregnancy itself and the condition and
116.19 characteristics of the child upon birth is not privileged.

116.20 Sec. 144. Minnesota Statutes 2018, section 257B.01, subdivision 3, is amended to read:

116.21 Subd. 3. **Attending physician or advanced practice registered nurse.** "Attending
116.22 physician or advanced practice registered nurse" means a physician or advanced practice
116.23 registered nurse who has primary responsibility for the treatment and care of the designator.
116.24 If physicians or advanced practice registered nurses share responsibility, another physician
116.25 or advanced practice registered nurse is acting on the attending physician's or advanced
116.26 practice registered nurse's behalf, or no physician or advanced practice registered nurse has
116.27 primary responsibility, any physician or advanced practice registered nurse who is familiar
116.28 with the designator's medical condition may act as an attending physician or advanced
116.29 practice registered nurse under this chapter.

116.30 Sec. 145. Minnesota Statutes 2018, section 257B.01, subdivision 9, is amended to read:

116.31 Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written
116.32 finding made by an attending physician or advanced practice registered nurse which states

117.1 that the designator suffers from a physically incapacitating disease or injury. No identification
117.2 of the illness in question is required.

117.3 Sec. 146. Minnesota Statutes 2018, section 257B.01, subdivision 10, is amended to read:

117.4 Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written
117.5 finding made by an attending physician or advanced practice registered nurse which states
117.6 the nature, extent, and probable duration of the designator's mental or organic incapacity.

117.7 Sec. 147. Minnesota Statutes 2018, section 257B.06, subdivision 7, is amended to read:

117.8 Subd. 7. **Restored capacity.** If a licensed physician or advanced practice registered
117.9 nurse determines that the designator has regained capacity, the co-custodian's authority that
117.10 commenced on the occurrence of a triggering event becomes inactive. Failure of a
117.11 co-custodian to immediately return the child(ren) to the designator's care entitles the
117.12 designator to an emergency hearing within five days of a request for a hearing.

117.13 Sec. 148. **REPEALER.**

117.14 Minnesota Rules, part 9505.0365, subpart 3, is repealed.

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.