

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.23, subdivision 2; 62J.495, subdivision

1.5 1a; 62J.496, subdivision 2; 62J.52, subdivision 2; 62J.823, subdivision 3; 62Q.184,

1.6 subdivision 1; 62Q.43, subdivisions 1, 2; 62Q.54; 62Q.57, subdivision 1; 62Q.73,

1.7 subdivision 7; 62Q.733, subdivision 3; 62Q.74, subdivision 1; 62S.08, subdivision

1.8 3; 62S.20, subdivision 5b; 62S.21, subdivision 2; 62S.268, subdivision 1; 144.3345,

1.9 subdivision 1; 144.3352; 144.34; 144.441, subdivisions 4, 5; 144.442, subdivision

1.10 1; 144.4803, subdivisions 1, 4, 10, by adding a subdivision; 144.4806; 144.4807,

1.11 subdivisions 1, 2, 4; 144.50, subdivision 2; 144.55, subdivisions 2, 6; 144.6501,

1.12 subdivision 7; 144.651, subdivisions 7, 8, 9, 10, 12, 14, 31, 33; 144.652, subdivision

1.13 2; 144.69; 144.7402, subdivision 2; 144.7406, subdivision 2; 144.7407, subdivision

1.14 2; 144.7414, subdivision 2; 144.7415, subdivision 2; 144.9502, subdivision 4;

1.15 144.966, subdivisions 3, 6; 144A.135; 144A.161, subdivisions 5, 5a, 5e, 5g;

1.16 144A.75, subdivisions 3, 6; 144A.752, subdivision 1; 145.853, subdivision 5;

1.17 145.892, subdivision 3; 145.94, subdivision 2; 145B.13; 145C.02; 145C.05,

1.18 subdivision 2; 145C.06; 145C.07, subdivision 1; 145C.16; 148.6438, subdivision

1.19 1; 151.19, subdivision 4; 151.21, subdivision 4a; 152.32, subdivision 3; 245.4871,

1.20 subdivision 27; 245.62, subdivision 3; 245A.143, subdivision 8; 245A.1435;

1.21 245C.02, subdivision 18; 245C.04, subdivision 1; 245D.02, subdivision 11;

1.22 245D.11, subdivision 2; 245D.22, subdivision 7; 245D.25, subdivision 2; 245G.08,

1.23 subdivisions 2, 3, 5; 245G.21, subdivisions 2, 3; 245G.22, subdivisions 3, 4, 6, 7,

1.24 16; 245H.11; 246.711, subdivision 2; 246.715, subdivision 2; 246.716, subdivision

1.25 2; 246.721; 246.722; 251.043, subdivision 1; 252A.02, subdivision 12; 252A.04,

1.26 subdivision 2; 252A.20, subdivision 1; 253B.03, subdivisions 4, 6d; 253B.06,

1.27 subdivisions 1, 2; 253B.07, subdivision 2; 253B.08, subdivision 5; 253B.092,

1.28 subdivisions 2, 3, 6, 8; 253B.0921; 253B.20, subdivisions 4, 6; 253B.23,

1.29 subdivision 4; 254A.08, subdivision 2; 256.9685, subdivisions 1a, 1b, 1c; 256.975,

1.30 subdivisions 7a, 11; 256B.038; 256B.04, subdivision 14a; 256B.043, subdivision

1.31 2; 256B.055, subdivision 12; 256B.0622, subdivisions 2b, 8; 256B.0623,

1.32 subdivision 2; 256B.0625, subdivisions 3, 4, 13, 17, 26, 28, 60a; 256B.0654,

1.33 subdivisions 1, 2a, 3, 4; 256B.0659, subdivisions 2, 4, 8, 11; 256B.0913,

1.34 subdivision 8; 256B.73, subdivision 5; 256J.08, subdivision 73a; 256R.44; 256R.54,

1.35 subdivisions 1, 2; 257.63, subdivision 3; 257B.01, subdivisions 3, 9, 10; 257B.06,

1.36 subdivision 7.

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.

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

3.2 Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a
3.3 number three qualified plan if it otherwise meets the requirements established by chapters
3.4 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in
3.5 Minnesota, and meets or exceeds the following minimum standards:

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

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

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

3.17 (1) hospital services;

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

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

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

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

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

3.27 (7) oxygen;

3.28 (8) anesthetics;

3.29 (9) prostheses other than dental but including scalp hair prostheses worn for hair loss
3.30 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

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

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

6.8 Sec. 4. Minnesota Statutes 2018, section 62J.23, subdivision 2, is amended to read:

6.9 Subd. 2. **Restrictions.** (a) From July 1, 1992, until rules are adopted by the commissioner
6.10 under this section, the restrictions in the federal Medicare antikickback statutes in section
6.11 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and
6.12 rules adopted under the federal statutes, apply to all persons in the state, regardless of whether
6.13 the person participates in any state health care program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.4 (1) provide clinical decision support;

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

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

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

8.9 Sec. 6. Minnesota Statutes 2018, section 62J.496, subdivision 2, is amended to read:

8.10 Subd. 2. **Eligibility.** (a) "Eligible borrower" means one of the following:

8.11 (1) federally qualified health centers;

8.12 (2) community clinics, as defined under section 145.9268;

8.13 (3) nonprofit or local unit of government hospitals licensed under sections 144.50 to
8.14 144.56;

8.15 (4) individual or small group physician or advanced practice registered nurse practices
8.16 that are focused primarily on primary care;

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

8.18 (6) local public health departments as defined in chapter 145A; and

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

8.22 (b) The commissioner shall administer the loan fund to prioritize support and assistance
8.23 to:

8.24 (1) critical access hospitals;

8.25 (2) federally qualified health centers;

8.26 (3) entities that serve uninsured, underinsured, and medically underserved individuals,
8.27 regardless of whether such area is urban or rural;

8.28 (4) individual or small group practices that are primarily focused on primary care;

8.29 (5) nursing facilities certified to participate in the medical assistance program; and

9.1 (6) providers enrolled in the elderly waiver program of customized living or 24-hour
9.2 customized living of the medical assistance program, if at least half of their annual operating
9.3 revenue is paid under the medical assistance program.

9.4 (c) An eligible applicant must submit a loan application to the commissioner of health
9.5 on forms prescribed by the commissioner. The application must include, at a minimum:

9.6 (1) the amount of the loan requested and a description of the purpose or project for which
9.7 the loan proceeds will be used;

9.8 (2) a quote from a vendor;

9.9 (3) a description of the health care entities and other groups participating in the project;

9.10 (4) evidence of financial stability and a demonstrated ability to repay the loan;

9.11 (5) a description of how the system to be financed interoperates or plans in the future
9.12 to interoperate with other health care entities and provider groups located in the same
9.13 geographical area;

9.14 (6) a plan on how the certified electronic health record technology will be maintained
9.15 and supported over time; and

9.16 (7) any other requirements for applications included or developed pursuant to section
9.17 3014 of the HITECH Act.

9.18 Sec. 7. Minnesota Statutes 2018, section 62J.52, subdivision 2, is amended to read:

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

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

9.28 (c) Services to be billed using the uniform billing form CMS 1500 include physician
9.29 services and supplies, durable medical equipment, noninstitutional ambulance services,
9.30 independent ancillary services including occupational therapy, physical therapy, speech
9.31 therapy and audiology, home infusion therapy, podiatry services, optometry services, mental
9.32 health licensed professional services, substance abuse licensed professional services, ~~nursing~~

10.1 ~~practitioner professional services, certified registered nurse anesthetists~~ advanced practice
 10.2 registered nurse services, chiropractors, physician assistants, laboratories, medical suppliers,
 10.3 waived services, personal care attendants, and other health care providers such as day
 10.4 activity centers and freestanding ambulatory surgical centers.

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

10.8 Sec. 8. Minnesota Statutes 2018, section 62J.823, subdivision 3, is amended to read:

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

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

10.16 (2) at least one of the following:

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

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

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

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

10.22 Sec. 9. Minnesota Statutes 2018, section 62Q.184, subdivision 1, is amended to read:

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

10.25 (b) "Clinical practice guideline" means a systematically developed statement to assist
 10.26 health care providers and enrollees in making decisions about appropriate health care services
 10.27 for specific clinical circumstances and conditions developed independently of a health plan
 10.28 company, pharmaceutical manufacturer, or any entity with a conflict of interest.

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

11.1 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but
 11.2 does not include a managed care organization or county-based purchasing plan participating
 11.3 in a public program under chapter 256B or 256L, or an integrated health partnership under
 11.4 section 256B.0755.

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

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

11.13 Sec. 10. Minnesota Statutes 2018, section 62Q.43, subdivision 1, is amended to read:

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

11.19 Sec. 11. Minnesota Statutes 2018, section 62Q.43, subdivision 2, is amended to read:

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

11.28 Sec. 12. Minnesota Statutes 2018, section 62Q.54, is amended to read:

11.29 **62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.**

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

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

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

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

12.9 Sec. 13. Minnesota Statutes 2018, section 62Q.57, subdivision 1, is amended to read:

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

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

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

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

12.21 Sec. 14. Minnesota Statutes 2018, section 62Q.73, subdivision 7, is amended to read:

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

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

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

13.1 medical necessity determination, the external review must determine whether the adverse
 13.2 determination was consistent with the definition of medically necessary care in section
 13.3 62Q.53, subdivision 2.

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

13.11 Sec. 15. Minnesota Statutes 2018, section 62Q.733, subdivision 3, is amended to read:

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

13.16 Sec. 16. Minnesota Statutes 2018, section 62Q.74, subdivision 1, is amended to read:

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

- 13.19 (1) health;
- 13.20 (2) no-fault automobile medical benefits; or
- 13.21 (3) workers' compensation medical benefits.

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

13.25 Sec. 17. Minnesota Statutes 2018, section 62S.08, subdivision 3, is amended to read:

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

- 13.28 COMPANY NAME
- 13.29 ADDRESS - CITY AND STATE
- 13.30 TELEPHONE NUMBER
- 13.31 LONG-TERM CARE INSURANCE

14.1 OUTLINE OF COVERAGE

14.2 Policy Number or Group Master Policy and Certificate Number

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.9 (9) BENEFITS PROVIDED BY THIS POLICY.

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

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

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

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

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

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

16.23 (10) LIMITATIONS AND EXCLUSIONS:

16.24 Describe:

16.25 (a) preexisting conditions;

16.26 (b) noneligible facilities/provider;

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

16.29 (d) exclusions/exceptions; and

16.30 (e) limitations.

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

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

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

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

17.10 (b) any automatic benefit adjustment provisions;

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

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

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

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

17.24 (13) PREMIUM.

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

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

17.28 (14) ADDITIONAL FEATURES.

17.29 (a) Indicate if medical underwriting is used.

17.30 (b) Describe other important features.

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

18.6 Sec. 18. Minnesota Statutes 2018, section 62S.20, subdivision 5b, is amended to read:

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

18.15 Sec. 19. Minnesota Statutes 2018, section 62S.21, subdivision 2, is amended to read:

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

18.23 Sec. 20. Minnesota Statutes 2018, section 62S.268, subdivision 1, is amended to read:

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

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

18.31 (b) "Chronically ill individual" has the meaning prescribed for this term by section
18.32 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a

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

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

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

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

19.17 Sec. 21. Minnesota Statutes 2018, section 144.3345, subdivision 1, is amended to read:

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

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

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

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

19.27 (2) hospitals eligible for rural hospital capital improvement grants, as defined in section
19.28 144.148;

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

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

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

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

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

20.7 Sec. 22. Minnesota Statutes 2018, section 144.3352, is amended to read:

20.8 **144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT**
20.9 **IMMUNIZATION.**

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

20.13 Sec. 23. Minnesota Statutes 2018, section 144.34, is amended to read:

20.14 **144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.**

20.15 Any physician or advanced practice registered nurse having under professional care any
20.16 person whom the physician or advanced practice registered nurse believes to be suffering
20.17 from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas,
20.18 wood alcohol, or mercury, or their compounds, or from anthrax or from compressed-air
20.19 illness or any other disease contracted as a result of the nature of the employment of such
20.20 person shall within five days mail to the Department of Health a report stating the name,
20.21 address, and occupation of such patient, the name, address, and business of the patient's
20.22 employer, the nature of the disease, and such other information as may reasonably be required
20.23 by the department. The department shall prepare and furnish the physicians and advanced
20.24 practice registered nurses of this state suitable blanks for the reports herein required. No
20.25 report made pursuant to the provisions of this section shall be admissible as evidence of the
20.26 facts therein stated in any action at law or in any action under the Workers' Compensation
20.27 Act against any employer of such diseased person. The Department of Health is authorized
20.28 to investigate and to make recommendations for the elimination or prevention of occupational
20.29 diseases which have been reported to it, or which shall be reported to it, in accordance with
20.30 the provisions of this section. The department is also authorized to study and provide advice
20.31 in regard to conditions that may be suspected of causing occupational diseases. Information
20.32 obtained upon investigations made in accordance with the provisions of this section shall
20.33 not be admissible as evidence in any action at law to recover damages for personal injury

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

21.8 Sec. 24. Minnesota Statutes 2018, section 144.441, subdivision 4, is amended to read:

21.9 Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision
21.10 2, a person employed by the designated school or school district shall submit to the
21.11 administrator or other person having general control and supervision of the school one of
21.12 the following:

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

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

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

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

21.31 Sec. 25. Minnesota Statutes 2018, section 144.441, subdivision 5, is amended to read:

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

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

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

22.10 Sec. 26. Minnesota Statutes 2018, section 144.442, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

22.27 (7) that screening has been scheduled; and

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

23.1 Sec. 27. Minnesota Statutes 2018, section 144.4803, subdivision 1, is amended to read:

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

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

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

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

23.16 Sec. 28. Minnesota Statutes 2018, section 144.4803, is amended by adding a subdivision
23.17 to read:

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

23.21 Sec. 29. Minnesota Statutes 2018, section 144.4803, subdivision 4, is amended to read:

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

23.27 Sec. 30. Minnesota Statutes 2018, section 144.4803, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

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

24.24 Sec. 31. Minnesota Statutes 2018, section 144.4806, is amended to read:

24.25 **144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.**

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

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

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

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

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

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

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

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

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

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

25.28 Sec. 32. Minnesota Statutes 2018, section 144.4807, subdivision 1, is amended to read:

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

26.1 Sec. 33. Minnesota Statutes 2018, section 144.4807, subdivision 2, is amended to read:

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

26.6 Sec. 34. Minnesota Statutes 2018, section 144.4807, subdivision 4, is amended to read:

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

26.11 Sec. 35. Minnesota Statutes 2018, section 144.50, subdivision 2, is amended to read:

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

26.23 Sec. 36. Minnesota Statutes 2018, section 144.55, subdivision 2, is amended to read:

26.24 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the
26.25 meanings given:

26.26 (b) "Outpatient surgical center" or "center" means a freestanding facility organized for
26.27 the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed,
26.28 low-risk patients. Admissions are limited to procedures that utilize general anesthesia or
26.29 conscious sedation and that do not require overnight inpatient care. An outpatient surgical
26.30 center is not organized to provide regular emergency medical services and does not include
26.31 a physician's, advanced practice registered nurse's, or dentist's office or clinic for the practice
26.32 of medicine, the practice of dentistry, or the delivery of primary care.

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

27.3 Sec. 37. Minnesota Statutes 2018, section 144.55, subdivision 6, is amended to read:

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

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

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

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

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

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

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

27.18 Sec. 38. Minnesota Statutes 2018, section 144.6501, subdivision 7, is amended to read:

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

27.24 Sec. 39. Minnesota Statutes 2018, section 144.651, subdivision 7, is amended to read:

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

28.1 Sec. 40. Minnesota Statutes 2018, section 144.651, subdivision 8, is amended to read:

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

28.11 Sec. 41. Minnesota Statutes 2018, section 144.651, subdivision 9, is amended to read:

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

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

28.29 Sec. 42. Minnesota Statutes 2018, section 144.651, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

30.12 Sec. 43. Minnesota Statutes 2018, section 144.651, subdivision 12, is amended to read:

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

30.21 Sec. 44. Minnesota Statutes 2018, section 144.651, subdivision 14, is amended to read:

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

30.31 Sec. 45. Minnesota Statutes 2018, section 144.651, subdivision 31, is amended to read:

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

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

31.7 Sec. 46. Minnesota Statutes 2018, section 144.651, subdivision 33, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

32.6 (f) When determining nursing facility compliance with state and federal standards for
32.7 the use of physical restraints, the commissioner of health is bound by the statements and
32.8 determinations contained in the attending physician's or advanced practice registered nurse's
32.9 order regarding medical symptoms. For purposes of this order, "medical symptoms" include
32.10 the request by a competent resident, family member of a resident who is not competent, or
32.11 legally appointed conservator, guardian, or health care agent as defined under section
32.12 145C.01, that the facility provide a physical restraint in order to enhance the physical safety
32.13 of the resident.

32.14 Sec. 47. Minnesota Statutes 2018, section 144.652, subdivision 2, is amended to read:

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

32.26 Sec. 48. Minnesota Statutes 2018, section 144.69, is amended to read:

32.27 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

32.28 Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data
32.29 collected on individuals by the cancer surveillance system, including the names and personal
32.30 identifiers of persons required in section 144.68 to report, shall be private and may only be
32.31 used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68.
32.32 Any disclosure other than is provided for in this section and sections 144.671, 144.672, and
32.33 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by

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

33.5 Sec. 49. Minnesota Statutes 2018, section 144.7402, subdivision 2, is amended to read:

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

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

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

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

33.20 Sec. 50. Minnesota Statutes 2018, section 144.7406, subdivision 2, is amended to read:

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

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

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

34.1 medical treatment for the emergency medical services person under section 144.7414,
34.2 subdivision 2;

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

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

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

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

34.12 Sec. 51. Minnesota Statutes 2018, section 144.7407, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.27 Sec. 52. Minnesota Statutes 2018, section 144.7414, subdivision 2, is amended to read:

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

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

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

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

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

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

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

36.23 Sec. 53. Minnesota Statutes 2018, section 144.7415, subdivision 2, is amended to read:

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

36.30 Sec. 54. Minnesota Statutes 2018, section 144.9502, subdivision 4, is amended to read:

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

- 37.1 (1) whether the specimen was collected as a capillary or venous sample;
- 37.2 (2) the date the sample was collected;
- 37.3 (3) the results of the blood lead analysis;
- 37.4 (4) the date the sample was analyzed;
- 37.5 (5) the method of analysis used;
- 37.6 (6) the full name, address, and phone number of the laboratory performing the analysis;
- 37.7 (7) the full name, address, and phone number of the physician, advanced practice
- 37.8 registered nurse, or facility requesting the analysis;
- 37.9 (8) the full name, address, and phone number of the person with the blood lead level,
- 37.10 and the person's birthdate, gender, and race.

37.11 Sec. 55. Minnesota Statutes 2018, section 144.966, subdivision 3, is amended to read:

37.12 Subd. 3. **Early hearing detection and intervention programs.** All hospitals shall

37.13 establish an early hearing detection and intervention (EHDI) program. Each EHDI program

37.14 shall:

37.15 (1) in advance of any hearing screening testing, provide to the newborn's or infant's

37.16 parents or parent information concerning the nature of the screening procedure, applicable

37.17 costs of the screening procedure, the potential risks and effects of hearing loss, and the

37.18 benefits of early detection and intervention;

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

37.20 (3) develop policies and procedures for screening and rescreening based on Department

37.21 of Health recommendations;

37.22 (4) provide appropriate training and monitoring of individuals responsible for performing

37.23 hearing screening tests as recommended by the Department of Health;

37.24 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain

37.25 in the hospital for a prolonged period, testing shall be performed prior to three months of

37.26 age or when medically feasible;

37.27 (6) develop and implement procedures for documenting the results of all hearing screening

37.28 tests;

37.29 (7) inform the newborn's or infant's parents or parent, primary care physician or advanced

37.30 practice registered nurse, and the Department of Health according to recommendations of

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

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

38.5 Sec. 56. Minnesota Statutes 2018, section 144.966, subdivision 6, is amended to read:

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

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

38.12 Sec. 57. Minnesota Statutes 2018, section 144A.135, is amended to read:

38.13 **144A.135 TRANSFER AND DISCHARGE APPEALS.**

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

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

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

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

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

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

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

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

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

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

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

39.27 (1) resident name;

39.28 (2) date of birth;

39.29 (3) Social Security number;

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

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

40.1 (6) date of admission to the facility;

40.2 (7) all current diagnoses;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41.8 Sec. 61. Minnesota Statutes 2018, section 144A.161, subdivision 5g, is amended to read:

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

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

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

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

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

41.28 Sec. 62. Minnesota Statutes 2018, section 144A.75, subdivision 3, is amended to read:

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

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

42.3 Sec. 63. Minnesota Statutes 2018, section 144A.75, subdivision 6, is amended to read:

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

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

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

42.13 Sec. 64. Minnesota Statutes 2018, section 144A.752, subdivision 1, is amended to read:

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

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

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

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

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

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

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

43.1 Sec. 65. Minnesota Statutes 2018, section 145.853, subdivision 5, is amended to read:

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

43.11 Sec. 66. Minnesota Statutes 2018, section 145.892, subdivision 3, is amended to read:

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

43.15 Sec. 67. Minnesota Statutes 2018, section 145.94, subdivision 2, is amended to read:

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

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

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

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

44.1 Sec. 68. Minnesota Statutes 2018, section 145B.13, is amended to read:

44.2 **145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.**

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

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

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

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

44.15 Sec. 69. Minnesota Statutes 2018, section 145C.02, is amended to read:

44.16 **145C.02 HEALTH CARE DIRECTIVE.**

44.17 A principal with the capacity to do so may execute a health care directive. A health care
44.18 directive may include one or more health care instructions to direct health care providers,
44.19 others assisting with health care, family members, and a health care agent. A health care
44.20 directive may include a health care power of attorney to appoint a health care agent to make
44.21 health care decisions for the principal when the principal, in the judgment of the principal's
44.22 attending physician or advanced practice registered nurse, lacks decision-making capacity,
44.23 unless otherwise specified in the health care directive.

44.24 Sec. 70. Minnesota Statutes 2018, section 145C.05, subdivision 2, is amended to read:

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

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

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

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

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

45.7 (5) a document of gift for the purpose of making an anatomical gift, as set forth in chapter
45.8 525A, or an amendment to, revocation of, or refusal to make an anatomical gift;

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

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

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

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

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

45.21 (11) health care instructions regarding artificially administered nutrition or hydration.

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

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

45.29 (2) a principal who in good faith does not generally select a physician, advanced practice
45.30 registered nurse, or a health care facility for the principal's health care needs may include
45.31 a statement appointing an individual who may determine the principal's decision-making
45.32 capacity, provided that if the need to determine the principal's capacity arises when the

46.1 principal is receiving care under the direction of an attending physician or advanced practice
46.2 registered nurse in a health care facility, the determination must be made by an attending
46.3 physician or advanced practice registered nurse after consultation with the appointed
46.4 individual.

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

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

46.11 Sec. 71. Minnesota Statutes 2018, section 145C.06, is amended to read:

46.12 **145C.06 WHEN EFFECTIVE.**

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

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

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

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

46.23 Sec. 72. Minnesota Statutes 2018, section 145C.07, subdivision 1, is amended to read:

46.24 Subdivision 1. **Authority.** The health care agent has authority to make any particular
46.25 health care decision only if the principal lacks decision-making capacity, in the determination
46.26 of the attending physician or advanced practice registered nurse, to make or communicate
46.27 that health care decision; or if other conditions for effectiveness otherwise specified by the
46.28 principal have been met. The physician, advanced practice registered nurse, or other health
46.29 care provider shall continue to obtain the principal's informed consent to all health care
46.30 decisions for which the principal has decision-making capacity, unless other conditions for
46.31 effectiveness otherwise specified by the principal have been met. An alternate health care
46.32 agent has authority to act if the primary health care agent is not reasonably available to act.

47.1 Sec. 73. Minnesota Statutes 2018, section 145C.16, is amended to read:

47.2 **145C.16 SUGGESTED FORM.**

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

47.4 HEALTH CARE DIRECTIVE

47.5 I,, understand this document allows me to do ONE OR BOTH of the
47.6 following:

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

47.12 AND/OR

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

47.17 PART I: APPOINTMENT OF HEALTH CARE AGENT

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

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

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

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

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

47.28 Telephone number of my health care agent:.....

47.29 Address of my health care agent:.....

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

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

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

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

48.7 THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO

48.8 DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

48.9 (I know I can change these choices)

48.10 My health care agent is automatically given the powers listed below in (A) through (D).

48.11 My health care agent must follow my health care instructions in this document or any other
 48.12 instructions I have given to my agent. If I have not given health care instructions, then my
 48.13 agent must act in my best interest.

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

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

48.20 (B) Choose my health care providers.

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

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

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

48.27

48.28

48.29

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

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

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

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

49.9
 49.10
 49.11

49.12 PART II: HEALTH CARE INSTRUCTIONS

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

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

49.19 THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

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

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

49.23 My goals for my health care:.....
 49.24
 49.25

49.26 My fears about my health care:.....
 49.27
 49.28

49.29 My spiritual or religious beliefs and traditions:.....
 49.30

50.1

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

50.3

50.4

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

50.6

50.7

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

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

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

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

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

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

50.19

50.20

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

50.22

50.23

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

50.26

50.27

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

51.1

51.2

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

51.6

51.7

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

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

51.10

51.11

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

51.13

51.14

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

51.16

51.17

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

51.19

51.20

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

51.22

51.23

51.24 Any other things:.....

51.25

51.26

51.27 PART III: MAKING THE DOCUMENT LEGAL

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

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

52.6

52.7 My Signature

52.8 Date signed:

52.9 Date of birth:

52.10 Address:

52.11

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

52.13

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

52.15

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

52.17 Option 1: Notary Public

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

52.22

52.23 (Signature of Notary) (Notary Stamp)

52.24 Option 2: Two Witnesses

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

52.28 Witness One:

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

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

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

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

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

53.6

53.7 (Signature of Witness One)

53.8 Address:

53.9

53.10 Witness Two:

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

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

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

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

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

53.20

53.21 (Signature of Witness Two)

53.22 Address:

53.23

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

54.1 Sec. 74. Minnesota Statutes 2018, section 148.6438, subdivision 1, is amended to read:

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

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

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

54.14 Sec. 75. Minnesota Statutes 2018, section 151.19, subdivision 4, is amended to read:

54.15 Subd. 4. **Licensing of physicians and advanced practice registered nurses to dispense**
54.16 **drugs; renewals.** (a) The board may grant a license to any physician licensed under chapter
54.17 147 or advanced practice registered nurse licensed under chapter 148 who provides services
54.18 in a health care facility located in a designated health professional shortage area authorizing
54.19 the physician or advanced practice registered nurse to dispense drugs to individuals for
54.20 whom pharmaceutical care is not reasonably available. The license may be renewed annually.
54.21 Any physician or advanced practice registered nurse licensed under this subdivision shall
54.22 be limited to dispensing drugs in a limited service pharmacy and shall be governed by the
54.23 rules adopted by the board when dispensing drugs.

54.24 (b) For the purposes of this subdivision, pharmaceutical care is not reasonably available
54.25 if the limited service pharmacy in which the physician or advanced practice registered nurse
54.26 is dispensing drugs is located in a health professional shortage area, and no other licensed
54.27 pharmacy is located within 15 miles of the limited service pharmacy.

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

54.32 (d) Notwithstanding section 151.102, a physician or advanced practice registered nurse
54.33 granted a license under this subdivision may be assisted by a pharmacy technician if the

55.1 technician holds a valid certification from the Pharmacy Technician Certification Board or
55.2 from another national certification body for pharmacy technicians that requires passage of
55.3 a nationally recognized psychometrically valid certification examination for certification
55.4 as determined by the board. The physician or advanced practice registered nurse may
55.5 supervise the pharmacy technician as long as the physician or advanced practice registered
55.6 nurse assumes responsibility for all functions performed by the technician. For purposes of
55.7 this subdivision, supervision does not require the physician or advanced practice registered
55.8 nurse to be physically present if the physician, advanced practice registered nurse, or a
55.9 licensed pharmacist is available, either electronically or by telephone.

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

55.13 Sec. 76. Minnesota Statutes 2018, section 151.21, subdivision 4a, is amended to read:

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

55.20 Sec. 77. Minnesota Statutes 2018, section 152.32, subdivision 3, is amended to read:

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

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

55.31 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
55.32 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
55.33 may not discriminate against a person in hiring, termination, or any term or condition of

56.1 employment, or otherwise penalize a person, if the discrimination is based upon either of
56.2 the following:

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

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

56.8 (d) An employee who is required to undergo employer drug testing pursuant to section
56.9 181.953 may present verification of enrollment in the patient registry as part of the employee's
56.10 explanation under section 181.953, subdivision 6.

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

56.17 Sec. 78. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

56.18 Subd. 27. **Mental health professional.** "Mental health professional" means a person
56.19 providing clinical services in the diagnosis and treatment of children's emotional disorders.
56.20 A mental health professional must have training and experience in working with children
56.21 consistent with the age group to which the mental health professional is assigned. A mental
56.22 health professional must be qualified in at least one of the following ways:

56.23 (1) in psychiatric nursing, the mental health professional must be a registered nurse who
56.24 is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist or
56.25 certified nurse practitioner in child and adolescent psychiatric or mental health nursing by
56.26 a national nurse certification organization or who has a master's degree in nursing or one
56.27 of the behavioral sciences or related fields from an accredited college or university or its
56.28 equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery
56.29 of clinical services in the treatment of mental illness;

56.30 (2) in clinical social work, the mental health professional must be a person licensed as
56.31 an independent clinical social worker under chapter 148D, or a person with a master's degree
56.32 in social work from an accredited college or university, with at least 4,000 hours of

57.1 post-master's supervised experience in the delivery of clinical services in the treatment of
57.2 mental disorders;

57.3 (3) in psychology, the mental health professional must be an individual licensed by the
57.4 board of psychology under sections 148.88 to 148.98 who has stated to the board of
57.5 psychology competencies in the diagnosis and treatment of mental disorders;

57.6 (4) in psychiatry, the mental health professional must be a physician licensed under
57.7 chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible
57.8 for board certification in psychiatry or an osteopathic physician licensed under chapter 147
57.9 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible
57.10 for board certification in psychiatry;

57.11 (5) in marriage and family therapy, the mental health professional must be a marriage
57.12 and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of
57.13 post-master's supervised experience in the delivery of clinical services in the treatment of
57.14 mental disorders or emotional disturbances;

57.15 (6) in licensed professional clinical counseling, the mental health professional shall be
57.16 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours
57.17 of post-master's supervised experience in the delivery of clinical services in the treatment
57.18 of mental disorders or emotional disturbances; or

57.19 (7) in allied fields, the mental health professional must be a person with a master's degree
57.20 from an accredited college or university in one of the behavioral sciences or related fields,
57.21 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
57.22 services in the treatment of emotional disturbances.

57.23 Sec. 79. Minnesota Statutes 2018, section 245.62, subdivision 3, is amended to read:

57.24 Subd. 3. **Clinical supervisor.** All community mental health center services shall be
57.25 provided under the clinical supervision of a licensed psychologist licensed under sections
57.26 148.88 to 148.98, an advanced practice registered nurse certified in mental health, or a
57.27 physician who is board certified or eligible for board certification in psychiatry, and who
57.28 is licensed under section 147.02.

57.29 Sec. 80. Minnesota Statutes 2018, section 245A.143, subdivision 8, is amended to read:

57.30 Subd. 8. **Nutritional services.** (a) The license holder shall ensure that food served is
57.31 nutritious and meets any special dietary needs of the participants as prescribed by the

58.1 participant's physician, advanced practice registered nurse, or dietitian as specified in the
58.2 service delivery plan.

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

58.5 Sec. 81. Minnesota Statutes 2018, section 245A.1435, is amended to read:

58.6 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT DEATH**
58.7 **IN LICENSED PROGRAMS.**

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

58.17 (b) The license holder must place the infant in a crib directly on a firm mattress with a
58.18 fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and
58.19 overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of
58.20 the sheet with reasonable effort. The license holder must not place anything in the crib with
58.21 the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title
58.22 16, part 1511. The requirements of this section apply to license holders serving infants
58.23 younger than one year of age. Licensed child care providers must meet the crib requirements
58.24 under section 245A.146. A correction order shall not be issued under this paragraph unless
58.25 there is evidence that a violation occurred when an infant was present in the license holder's
58.26 care.

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

59.1 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
59.2 for an infant of any age and is prohibited for any infant who has begun to roll over
59.3 independently. However, with the written consent of a parent or guardian according to this
59.4 paragraph, a license holder may place the infant who has not yet begun to roll over on its
59.5 own down to sleep in a one-piece sleeper equipped with an attached system that fastens
59.6 securely only across the upper torso, with no constriction of the hips or legs, to create a
59.7 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
59.8 the license holder must obtain informed written consent for the use of swaddling from the
59.9 parent or guardian of the infant on a form provided by the commissioner and prepared in
59.10 partnership with the Minnesota Sudden Infant Death Center.

59.11 Sec. 82. Minnesota Statutes 2018, section 245C.02, subdivision 18, is amended to read:

59.12 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
59.13 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
59.14 the care of a physician or advanced practice registered nurse whether or not the care of a
59.15 physician or advanced practice registered nurse was sought, or abuse resulting in serious
59.16 injury.

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

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

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

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

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

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

60.1 Sec. 83. Minnesota Statutes 2018, section 245C.04, subdivision 1, is amended to read:

60.2 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
60.3 shall conduct a background study of an individual required to be studied under section
60.4 245C.03, subdivision 1, at least upon application for initial license for all license types.

60.5 (b) The commissioner shall conduct a background study of an individual required to be
60.6 studied under section 245C.03, subdivision 1, including a child care background study
60.7 subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed
60.8 child care center, certified license-exempt child care center, or legal nonlicensed child care
60.9 provider, on a schedule determined by the commissioner. Except as provided in section
60.10 245C.05, subdivision 5a, a child care background study must include submission of
60.11 fingerprints for a national criminal history record check and a review of the information
60.12 under section 245C.08. A background study for a child care program must be repeated
60.13 within five years from the most recent study conducted under this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

61.19 (1) except as provided in section 245C.05, subdivision 5a, the county shall collect and
61.20 forward to the commissioner the information required under section 245C.05, subdivision
61.21 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a), (b), and (d), for background
61.22 studies conducted by the commissioner for all family adult day services, for adult foster
61.23 care when the adult foster care license holder resides in the adult foster care residence, and
61.24 for family child care and legal nonlicensed child care authorized under chapter 119B;

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

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

61.32 (g) Applicants for licensure, license holders, and other entities as provided in this chapter
61.33 must submit completed background study requests to the commissioner using the electronic

62.1 system known as NETStudy before individuals specified in section 245C.03, subdivision
62.2 1, begin positions allowing direct contact in any licensed program.

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

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

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

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

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

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

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

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

62.27 Sec. 84. Minnesota Statutes 2018, section 245D.02, subdivision 11, is amended to read:

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

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

62.32 (2) a person's death;

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

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

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

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

63.10 (7) conduct by a person receiving services against another person receiving services
63.11 that:

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

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

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

63.16 or

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

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

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

63.22 (10) a report of alleged or suspected child or vulnerable adult maltreatment under section
63.23 626.556 or 626.557.

63.24 Sec. 85. Minnesota Statutes 2018, section 245D.11, subdivision 2, is amended to read:

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

63.27 (1) use of universal precautions and sanitary practices in compliance with section
63.28 245D.06, subdivision 2, clause (5);

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

64.1 (3) safe medication assistance and administration according to the requirements in
64.2 sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
64.3 consultation with a registered nurse, ~~nurse practitioner~~ advanced practice registered nurse,
64.4 physician assistant, or medical doctor and require completion of medication administration
64.5 training according to the requirements in section 245D.09, subdivision 4a, paragraph (d).

64.6 Medication assistance and administration includes, but is not limited to:

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

64.8 (ii) medication setup;

64.9 (iii) medication administration;

64.10 (iv) medication storage and security;

64.11 (v) medication documentation and charting;

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

64.14 (vii) coordination of medication refills;

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

64.16 (ix) communicating with the pharmacy; and

64.17 (x) coordination and communication with prescriber;

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

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

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

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

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

65.5 (7) a procedure for the review of incidents and emergencies to identify trends or patterns,
65.6 and corrective action if needed. The license holder must establish and maintain a
65.7 record-keeping system for the incident and emergency reports. Each incident and emergency
65.8 report file must contain a written summary of the incident. The license holder must conduct
65.9 a review of incident reports for identification of incident patterns, and implementation of
65.10 corrective action as necessary to reduce occurrences. Each incident report must include:

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

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

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

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

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

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

65.23 Sec. 86. Minnesota Statutes 2018, section 245D.22, subdivision 7, is amended to read:

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

66.1 Sec. 87. Minnesota Statutes 2018, section 245D.25, subdivision 2, is amended to read:

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

66.6 Sec. 88. Minnesota Statutes 2018, section 245G.08, subdivision 2, is amended to read:

66.7 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
66.8 obtaining a medical intervention for a client, that are approved in writing by a physician
66.9 who is licensed under chapter 147 or advanced practice registered nurse who is licensed
66.10 under chapter 148, unless:

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

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

66.14 Sec. 89. Minnesota Statutes 2018, section 245G.08, subdivision 3, is amended to read:

66.15 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone
66.16 available for emergency treatment of opioid overdose must have a written standing order
66.17 protocol by a physician who is licensed under chapter 147 or advanced practice registered
66.18 nurse who is licensed under chapter 148, that permits the license holder to maintain a supply
66.19 of naloxone on site, and must require staff to undergo specific training in administration of
66.20 naloxone.

66.21 Sec. 90. Minnesota Statutes 2018, section 245G.08, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

67.19 (3) a provision that a client may carry emergency medication such as nitroglycerin as
67.20 instructed by the client's physician or advanced practice registered nurse;

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

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

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

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

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

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

68.3 Sec. 91. Minnesota Statutes 2018, section 245G.21, subdivision 2, is amended to read:

68.4 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
68.5 the license holder. The license holder must set and post a notice of visiting rules and hours,
68.6 including both day and evening times. A client's right to receive visitors other than a personal
68.7 physician or advanced practice registered nurse, religious adviser, county case manager,
68.8 parole or probation officer, or attorney may be subject to visiting hours established by the
68.9 license holder for all clients. The treatment director or designee may impose limitations as
68.10 necessary for the welfare of a client provided the limitation and the reasons for the limitation
68.11 are documented in the client's file. A client must be allowed to receive visits at all reasonable
68.12 times from the client's personal physician or advanced practice registered nurse, religious
68.13 adviser, county case manager, parole or probation officer, and attorney.

68.14 Sec. 92. Minnesota Statutes 2018, section 245G.21, subdivision 3, is amended to read:

68.15 Subd. 3. **Client property management.** A license holder who provides room and board
68.16 and treatment services to a client in the same facility, and any license holder that accepts
68.17 client property must meet the requirements for handling client funds and property in section
68.18 245A.04, subdivision 13. License holders:

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

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

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

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

68.28 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
68.29 609.5316, must be given to the custody of a local law enforcement agency. If giving the
68.30 property to the custody of a local law enforcement agency violates Code of Federal
68.31 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug

69.1 paraphernalia, or drug container must be destroyed by a staff member designated by the
69.2 program director; and

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

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

69.11 Sec. 93. Minnesota Statutes 2018, section 245G.22, subdivision 3, is amended to read:

69.12 Subd. 3. **Medication orders.** Before the program may administer or dispense a medication
69.13 used for the treatment of opioid use disorder:

69.14 (1) a client-specific order must be received from an appropriately credentialed physician
69.15 or advanced practice registered nurse who is enrolled as a Minnesota health care programs
69.16 provider and meets all applicable provider standards;

69.17 (2) the signed order must be documented in the client's record; and

69.18 (3) if the physician or advanced practice registered nurse that issued the order is not able
69.19 to sign the order when issued, the unsigned order must be entered in the client record at the
69.20 time it was received, and the physician or advanced practice registered nurse must review
69.21 the documentation and sign the order in the client's record within 72 hours of the medication
69.22 being ordered. The license holder must report to the commissioner any medication error
69.23 that endangers a client's health, as determined by the medical director.

69.24 Sec. 94. Minnesota Statutes 2018, section 245G.22, subdivision 4, is amended to read:

69.25 Subd. 4. **High dose requirements.** A client being administered or dispensed a dose
69.26 beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams
69.27 of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase,
69.28 must meet face-to-face with a prescribing physician or advanced practice registered nurse.
69.29 The meeting must occur before the administration or dispensing of the increased medication
69.30 dose.

70.1 Sec. 95. Minnesota Statutes 2018, section 245G.22, subdivision 6, is amended to read:

70.2 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
70.3 medication used for the treatment of opioid use disorder to the illicit market, medication
70.4 dispensed to a client for unsupervised use shall be subject to the following requirements:

70.5 (1) any client in an opioid treatment program may receive a single unsupervised use
70.6 dose for a day that the clinic is closed for business, including Sundays and state and federal
70.7 holidays; and

70.8 (2) other treatment program decisions on dispensing medications used for the treatment
70.9 of opioid use disorder to a client for unsupervised use shall be determined by the medical
70.10 director.

70.11 (b) In determining whether a client may be permitted unsupervised use of medications,
70.12 a physician or advanced practice registered nurse with authority to prescribe must consider
70.13 the criteria in this paragraph. The criteria in this paragraph must also be considered when
70.14 determining whether dispensing medication for a client's unsupervised use is appropriate
70.15 to increase or to extend the amount of time between visits to the program. The criteria are:

70.16 (1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,
70.17 and alcohol;

70.18 (2) regularity of program attendance;

70.19 (3) absence of serious behavioral problems at the program;

70.20 (4) absence of known recent criminal activity such as drug dealing;

70.21 (5) stability of the client's home environment and social relationships;

70.22 (6) length of time in comprehensive maintenance treatment;

70.23 (7) reasonable assurance that unsupervised use medication will be safely stored within
70.24 the client's home; and

70.25 (8) whether the rehabilitative benefit the client derived from decreasing the frequency
70.26 of program attendance outweighs the potential risks of diversion or unsupervised use.

70.27 (c) The determination, including the basis of the determination must be documented in
70.28 the client's medical record.

70.29 Sec. 96. Minnesota Statutes 2018, section 245G.22, subdivision 7, is amended to read:

70.30 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
70.31 physician or advanced practice registered nurse with authority to prescribe determines that

71.1 a client meets the criteria in subdivision 6 and may be dispensed a medication used for the
71.2 treatment of opioid addiction, the restrictions in this subdivision must be followed when
71.3 the medication to be dispensed is methadone hydrochloride.

71.4 (b) During the first 90 days of treatment, the unsupervised use medication supply must
71.5 be limited to a maximum of a single dose each week and the client shall ingest all other
71.6 doses under direct supervision.

71.7 (c) In the second 90 days of treatment, the unsupervised use medication supply must be
71.8 limited to two doses per week.

71.9 (d) In the third 90 days of treatment, the unsupervised use medication supply must not
71.10 exceed three doses per week.

71.11 (e) In the remaining months of the first year, a client may be given a maximum six-day
71.12 unsupervised use medication supply.

71.13 (f) After one year of continuous treatment, a client may be given a maximum two-week
71.14 unsupervised use medication supply.

71.15 (g) After two years of continuous treatment, a client may be given a maximum one-month
71.16 unsupervised use medication supply, but must make monthly visits to the program.

71.17 Sec. 97. Minnesota Statutes 2018, section 245G.22, subdivision 16, is amended to read:

71.18 Subd. 16. **Prescription monitoring program.** (a) The program must develop and
71.19 maintain a policy and procedure that requires the ongoing monitoring of the data from the
71.20 prescription monitoring program (PMP) for each client. The policy and procedure must
71.21 include how the program meets the requirements in paragraph (b).

71.22 (b) If a medication used for the treatment of substance use disorder is administered or
71.23 dispensed to a client, the license holder shall be subject to the following requirements:

71.24 (1) upon admission to a methadone clinic outpatient treatment program, a client must
71.25 be notified in writing that the commissioner of human services and the medical director
71.26 must monitor the PMP to review the prescribed controlled drugs a client received;

71.27 (2) the medical director or the medical director's delegate must review the data from the
71.28 PMP described in section 152.126 before the client is ordered any controlled substance, as
71.29 defined under section 152.126, subdivision 1, paragraph (c), including medications used
71.30 for the treatment of opioid addiction, and the medical director's or the medical director's
71.31 delegate's subsequent reviews of the PMP data must occur at least every 90 days;

71.32 (3) a copy of the PMP data reviewed must be maintained in the client's file;

72.1 (4) when the PMP data contains a recent history of multiple prescribers or multiple
72.2 prescriptions for controlled substances, the physician's or advanced practice registered
72.3 nurse's review of the data and subsequent actions must be documented in the client's file
72.4 within 72 hours and must contain the medical director's determination of whether or not the
72.5 prescriptions place the client at risk of harm and the actions to be taken in response to the
72.6 PMP findings. The provider must conduct subsequent reviews of the PMP on a monthly
72.7 basis; and

72.8 (5) if at any time the medical director believes the use of the controlled substances places
72.9 the client at risk of harm, the program must seek the client's consent to discuss the client's
72.10 opioid treatment with other prescribers and must seek the client's consent for the other
72.11 prescriber to disclose to the opioid treatment program's medical director the client's condition
72.12 that formed the basis of the other prescriptions. If the information is not obtained within
72.13 seven days, the medical director must document whether or not changes to the client's
72.14 medication dose or number of unsupervised use doses are necessary until the information
72.15 is obtained.

72.16 (c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop
72.17 and implement an electronic system for the commissioner to routinely access the PMP data
72.18 to determine whether any client enrolled in an opioid addiction treatment program licensed
72.19 according to this section was prescribed or dispensed a controlled substance in addition to
72.20 that administered or dispensed by the opioid addiction treatment program. When the
72.21 commissioner determines there have been multiple prescribers or multiple prescriptions of
72.22 controlled substances for a client, the commissioner shall:

72.23 (1) inform the medical director of the opioid treatment program only that the
72.24 commissioner determined the existence of multiple prescribers or multiple prescriptions of
72.25 controlled substances; and

72.26 (2) direct the medical director of the opioid treatment program to access the data directly,
72.27 review the effect of the multiple prescribers or multiple prescriptions, and document the
72.28 review.

72.29 (d) If determined necessary, the commissioner shall seek a federal waiver of, or exception
72.30 to, any applicable provision of Code of Federal Regulations, title 42, section 2.34 (c), before
72.31 implementing this subdivision.

73.1 Sec. 98. Minnesota Statutes 2018, section 245H.11, is amended to read:

73.2 **245H.11 REPORTING.**

73.3 (a) The certification holder must comply with the reporting requirements for abuse and
73.4 neglect specified in section 626.556. A person mandated to report physical or sexual child
73.5 abuse or neglect occurring within a certified center shall report the information to the
73.6 commissioner.

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

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

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

73.11 Sec. 99. Minnesota Statutes 2018, section 246.711, subdivision 2, is amended to read:

73.12 Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections
73.13 246.71 to 246.722 when all of the following conditions are met:

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

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

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

73.22 Sec. 100. Minnesota Statutes 2018, section 246.715, subdivision 2, is amended to read:

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

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

73.29 (2) a licensed physician or advanced practice registered nurse has determined that a
73.30 significant exposure has occurred under section 246.711 and has documented that blood-borne

74.1 pathogen test results are needed for beginning, modifying, continuing, or discontinuing
74.2 medical treatment for the employee as recommended by the most current guidelines of the
74.3 United States Public Health Service;

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

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

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

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

74.13 Sec. 101. Minnesota Statutes 2018, section 246.716, subdivision 2, is amended to read:

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

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

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

74.27 (3) a physician or advanced practice registered nurse has documented that the employee
74.28 has provided a blood sample and consented to testing for blood-borne pathogens and
74.29 blood-borne pathogen test results are needed for beginning, continuing, modifying, or
74.30 discontinuing medical treatment for the employee under section 246.721.

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

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

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

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

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

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

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

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

75.20 Sec. 102. Minnesota Statutes 2018, section 246.721, is amended to read:

75.21 **246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.**

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

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

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

75.30 (2) a process for an infectious disease specialist, or a licensed physician or advanced
75.31 practice registered nurse who is knowledgeable about the most current recommendations
75.32 of the United States Public Health Service in consultation with an infectious disease specialist,

76.1 (i) to determine whether a significant exposure to one or more blood-borne pathogens has
76.2 occurred, and (ii) to provide, under the direction of a licensed physician or advanced practice
76.3 registered nurse, a recommendation or recommendations for follow-up treatment appropriate
76.4 to the particular blood-borne pathogen or pathogens for which a significant exposure has
76.5 been determined;

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

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

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

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

76.17 Sec. 103. Minnesota Statutes 2018, section 246.722, is amended to read:

76.18 **246.722 IMMUNITY.**

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

76.24 Sec. 104. Minnesota Statutes 2018, section 251.043, subdivision 1, is amended to read:

76.25 Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in the preceding
76.26 section, the workers' compensation division finds that an employee is suffering from
76.27 tuberculosis contracted in the institution or department by contact with inmates or patients
76.28 therein or by contact with tuberculosis contaminated material therein, it shall order the
76.29 employee to seek the services of a physician, advanced practice registered nurse, or medical
76.30 care facility. There shall be paid to the physician, advanced practice registered nurse, or
76.31 facility where the employee may be received, the same fee for the maintenance and care of
76.32 the person as is received by the institution for the maintenance and care of a nonresident

77.1 patient. If the employee worked in a state hospital or nursing home, payment for the care
77.2 shall be made by the commissioner of human services. If employed in any other institution
77.3 or department the payment shall be made from funds allocated or appropriated for the
77.4 operation of the institution or department. If the employee dies from the effects of the disease
77.5 of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of
77.6 death, the workers' compensation division shall order payment to dependents as provided
77.7 for under the general provisions of the workers' compensation law.

77.8 Sec. 105. Minnesota Statutes 2018, section 252A.02, subdivision 12, is amended to read:

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

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

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

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

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

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

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

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

77.27 Sec. 106. Minnesota Statutes 2018, section 252A.04, subdivision 2, is amended to read:

77.28 Subd. 2. **Medication; treatment.** A proposed ward who, at the time the comprehensive
77.29 evaluation is to be performed, has been under medical care shall not be so under the influence
77.30 or so suffer the effects of drugs, medication, or other treatment as to be hampered in the
77.31 testing or evaluation process. When in the opinion of the licensed physician or advanced

78.1 practice registered nurse attending the proposed ward, the discontinuance of medication or
 78.2 other treatment is not in the proposed ward's best interest, the physician or advanced practice
 78.3 registered nurse shall record a list of all drugs, medication or other treatment which the
 78.4 proposed ward received 48 hours immediately prior to any examination, test or interview
 78.5 conducted in preparation for the comprehensive evaluation.

78.6 Sec. 107. Minnesota Statutes 2018, section 252A.20, subdivision 1, is amended to read:

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

78.16 Sec. 108. Minnesota Statutes 2018, section 253B.03, subdivision 4, is amended to read:

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

78.20 Sec. 109. Minnesota Statutes 2018, section 253B.03, subdivision 6d, is amended to read:

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

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

78.28 (c) A declaration is effective only if it is signed by the declarant and two witnesses. The
 78.29 witnesses must include a statement that they believe the declarant understands the nature
 78.30 and significance of the declaration. A declaration becomes operative when it is delivered
 78.31 to the declarant's physician, advanced practice registered nurse, or other mental health
 78.32 treatment provider. The physician, advanced practice registered nurse, or provider must

79.1 comply with it to the fullest extent possible, consistent with reasonable medical practice,
79.2 the availability of treatments requested, and applicable law. The physician, advanced practice
79.3 registered nurse, or provider shall continue to obtain the declarant's informed consent to all
79.4 intrusive mental health treatment decisions if the declarant is capable of informed consent.
79.5 A treatment provider may not require a person to make a declaration under this subdivision
79.6 as a condition of receiving services.

79.7 (d) The physician, advanced practice registered nurse, or other provider shall make the
79.8 declaration a part of the declarant's medical record. If the physician, advanced practice
79.9 registered nurse, or other provider is unwilling at any time to comply with the declaration,
79.10 the physician, advanced practice registered nurse, or provider must promptly notify the
79.11 declarant and document the notification in the declarant's medical record. If the declarant
79.12 has been committed as a patient under this chapter, the physician, advanced practice
79.13 registered nurse, or provider may subject a declarant to intrusive treatment in a manner
79.14 contrary to the declarant's expressed wishes, only upon order of the committing court. If
79.15 the declarant is not a committed patient under this chapter, the physician, advanced practice
79.16 registered nurse, or provider may subject the declarant to intrusive treatment in a manner
79.17 contrary to the declarant's expressed wishes, only if the declarant is committed as mentally
79.18 ill or mentally ill and dangerous to the public and a court order authorizing the treatment
79.19 has been issued.

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

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

79.29 (g) In addition to making a declaration under this subdivision, a competent adult may
79.30 delegate parental powers under section 524.5-211 or may nominate a guardian under sections
79.31 524.5-101 to 524.5-502.

79.32 Sec. 110. Minnesota Statutes 2018, section 253B.06, subdivision 1, is amended to read:

79.33 Subdivision 1. **Persons who are mentally ill or developmentally disabled.** Every
79.34 patient hospitalized as mentally ill or developmentally disabled pursuant to section 253B.04

80.1 or 253B.05 must be examined by a physician or advanced practice registered nurse as soon
80.2 as possible but no more than 48 hours following admission. The physician or advanced
80.3 practice registered nurse shall be knowledgeable and trained in the diagnosis of the alleged
80.4 disability related to the need for admission as a person who is mentally ill or developmentally
80.5 disabled.

80.6 Sec. 111. Minnesota Statutes 2018, section 253B.06, subdivision 2, is amended to read:

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

80.13 Sec. 112. Minnesota Statutes 2018, section 253B.07, subdivision 2, is amended to read:

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

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

80.26 (c) The petition shall be accompanied by a written statement by an examiner stating that
80.27 the examiner has examined the proposed patient within the 15 days preceding the filing of
80.28 the petition and is of the opinion that the proposed patient is suffering a designated disability
80.29 and should be committed to a treatment facility. The statement shall include the reasons for
80.30 the opinion. In the case of a commitment based on mental illness, the petition and the
80.31 examiner's statement shall include, to the extent this information is available, a statement
80.32 and opinion regarding the proposed patient's need for treatment with neuroleptic medication
80.33 and the patient's capacity to make decisions regarding the administration of neuroleptic

81.1 medications, and the reasons for the opinion. If use of neuroleptic medications is
81.2 recommended by the treating physician or advanced practice registered nurse, the petition
81.3 for commitment must, if applicable, include or be accompanied by a request for proceedings
81.4 under section 253B.092. Failure to include the required information regarding neuroleptic
81.5 medications in the examiner's statement, or to include a request for an order regarding
81.6 neuroleptic medications with the commitment petition, is not a basis for dismissing the
81.7 commitment petition. If a petitioner has been unable to secure a statement from an examiner,
81.8 the petition shall include documentation that a reasonable effort has been made to secure
81.9 the supporting statement.

81.10 Sec. 113. Minnesota Statutes 2018, section 253B.08, subdivision 5, is amended to read:

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

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

81.25 Sec. 114. Minnesota Statutes 2018, section 253B.092, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

82.16 Sec. 115. Minnesota Statutes 2018, section 253B.092, subdivision 3, is amended to read:

82.17 Subd. 3. **Emergency administration.** A treating physician or advanced practice registered
82.18 nurse may administer neuroleptic medication to a patient who does not have capacity to
82.19 make a decision regarding administration of the medication if the patient is in an emergency
82.20 situation. Medication may be administered for so long as the emergency continues to exist,
82.21 up to 14 days, if the treating physician or advanced practice registered nurse determines
82.22 that the medication is necessary to prevent serious, immediate physical harm to the patient
82.23 or to others. If a request for authorization to administer medication is made to the court
82.24 within the 14 days, the treating physician or advanced practice registered nurse may continue
82.25 the medication through the date of the first court hearing, if the emergency continues to
82.26 exist. If the request for authorization to administer medication is made to the court in
82.27 conjunction with a petition for commitment or early intervention and the court makes a
82.28 determination at the preliminary hearing under section 253B.07, subdivision 7, that there
82.29 is sufficient cause to continue the physician's or advanced practice registered nurse's order
82.30 until the hearing under section 253B.08, the treating physician or advanced practice registered
82.31 nurse may continue the medication until that hearing, if the emergency continues to exist.
82.32 The treatment facility shall document the emergency in the patient's medical record in
82.33 specific behavioral terms.

83.1 Sec. 116. Minnesota Statutes 2018, section 253B.092, subdivision 6, is amended to read:

83.2 Subd. 6. **Patients without capacity to make informed decision; substitute**
83.3 **decision-maker.** (a) Upon request of any person, and upon a showing that administration
83.4 of neuroleptic medications may be recommended and that the person may lack capacity to
83.5 make decisions regarding the administration of neuroleptic medication, the court shall
83.6 appoint a substitute decision-maker with authority to consent to the administration of
83.7 neuroleptic medication as provided in this section. A hearing is not required for an
83.8 appointment under this paragraph. The substitute decision-maker must be an individual or
83.9 a community or institutional multidisciplinary panel designated by the local mental health
83.10 authority. In appointing a substitute decision-maker, the court shall give preference to a
83.11 guardian or conservator, proxy, or health care agent with authority to make health care
83.12 decisions for the patient. The court may provide for the payment of a reasonable fee to the
83.13 substitute decision-maker for services under this section or may appoint a volunteer.

83.14 (b) If the person's treating physician or advanced practice registered nurse recommends
83.15 treatment with neuroleptic medication, the substitute decision-maker may give or withhold
83.16 consent to the administration of the medication, based on the standards under subdivision
83.17 7. If the substitute decision-maker gives informed consent to the treatment and the person
83.18 does not refuse, the substitute decision-maker shall provide written consent to the treating
83.19 physician or advanced practice registered nurse and the medication may be administered.
83.20 The substitute decision-maker shall also notify the court that consent has been given. If the
83.21 substitute decision-maker refuses or withdraws consent or the person refuses the medication,
83.22 neuroleptic medication may not be administered to the person without a court order or in
83.23 an emergency.

83.24 (c) A substitute decision-maker appointed under this section has access to the relevant
83.25 sections of the patient's health records on the past or present administration of medication.
83.26 The designated agency or a person involved in the patient's physical or mental health care
83.27 may disclose information to the substitute decision-maker for the sole purpose of performing
83.28 the responsibilities under this section. The substitute decision-maker may not disclose health
83.29 records obtained under this paragraph except to the extent necessary to carry out the duties
83.30 under this section.

83.31 (d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity
83.32 by a preponderance of the evidence. If a substitute decision-maker has been appointed by
83.33 the court, the court shall make findings regarding the patient's capacity to make decisions
83.34 regarding the administration of neuroleptic medications and affirm or reverse its appointment
83.35 of a substitute decision-maker. If the court affirms the appointment of the substitute

84.1 decision-maker, and if the substitute decision-maker has consented to the administration of
84.2 the medication and the patient has not refused, the court shall make findings that the substitute
84.3 decision-maker has consented and the treatment is authorized. If a substitute decision-maker
84.4 has not yet been appointed, upon request the court shall make findings regarding the patient's
84.5 capacity and appoint a substitute decision-maker if appropriate.

84.6 (e) If an order for civil commitment or early intervention did not provide for the
84.7 appointment of a substitute decision-maker or for the administration of neuroleptic
84.8 medication, the treatment facility may later request the appointment of a substitute
84.9 decision-maker upon a showing that administration of neuroleptic medications is
84.10 recommended and that the person lacks capacity to make decisions regarding the
84.11 administration of neuroleptic medications. A hearing is not required in order to administer
84.12 the neuroleptic medication unless requested under subdivision 10 or if the substitute
84.13 decision-maker withholds or refuses consent or the person refuses the medication.

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

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

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

84.22 Sec. 117. Minnesota Statutes 2018, section 253B.092, subdivision 8, is amended to read:

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

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

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

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

85.10 (e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic
85.11 medication and has applied the standards set forth in subdivision 7, the court may authorize
85.12 the treating facility and any other community or treatment facility to which the patient may
85.13 be transferred or provisionally discharged, to involuntarily administer the medication to the
85.14 patient. A copy of the order must be given to the patient, the patient's attorney, the county
85.15 attorney, and the treatment facility. The treatment facility may not begin administration of
85.16 the neuroleptic medication until it notifies the patient of the court's order authorizing the
85.17 treatment.

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

85.20 (g) The court may authorize the administration of neuroleptic medication until the
85.21 termination of a determinate commitment. If the patient is committed for an indeterminate
85.22 period, the court may authorize treatment of neuroleptic medication for not more than two
85.23 years, subject to the patient's right to petition the court for review of the order. The treatment
85.24 facility must submit annual reports to the court, which shall provide copies to the patient
85.25 and the respective attorneys.

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

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

86.1 Sec. 118. Minnesota Statutes 2018, section 253B.0921, is amended to read:

86.2 **253B.0921 ACCESS TO MEDICAL RECORDS.**

86.3 A treating physician or advanced practice registered nurse who makes medical decisions
86.4 regarding the prescription and administration of medication for treatment of a mental illness
86.5 has access to the relevant sections of a patient's health records on past administration of
86.6 medication at any treatment facility, if the patient lacks the capacity to authorize the release
86.7 of records. Upon request of a treating physician or advanced practice registered nurse under
86.8 this section, a treatment facility shall supply complete information relating to the past records
86.9 on administration of medication of a patient subject to this chapter. A patient who has the
86.10 capacity to authorize the release of data retains the right to make decisions regarding access
86.11 to medical records as provided by sections 144.291 to 144.298.

86.12 Sec. 119. Minnesota Statutes 2018, section 253B.20, subdivision 4, is amended to read:

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

86.22 Sec. 120. Minnesota Statutes 2018, section 253B.20, subdivision 6, is amended to read:

86.23 Subd. 6. **Notice to physician or advanced practice registered nurse.** The head of the
86.24 treatment facility shall notify the physician or advanced practice registered nurse of any
86.25 committed person at the time of the patient's discharge or provisional discharge, unless the
86.26 patient objects to the notice.

86.27 Sec. 121. Minnesota Statutes 2018, section 253B.23, subdivision 4, is amended to read:

86.28 Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or
86.29 information thought by them to be reliable, who act pursuant to any provision of this chapter
86.30 or who procedurally or physically assist in the commitment of any individual, pursuant to
86.31 this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege
86.32 otherwise existing between patient and physician, patient and advanced practice registered

87.1 nurse, patient and psychologist, patient and examiner, or patient and social worker, is waived
87.2 as to any physician, advanced practice registered nurse, psychologist, examiner, or social
87.3 worker who provides information with respect to a patient pursuant to any provision of this
87.4 chapter.

87.5 Sec. 122. Minnesota Statutes 2018, section 254A.08, subdivision 2, is amended to read:

87.6 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
87.7 program means a social rehabilitation program licensed by the Department of Human
87.8 Services under chapter 245A, and governed by the standards of Minnesota Rules, parts
87.9 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and
87.10 treatment by detoxifying and evaluating the person and providing entrance into a
87.11 comprehensive program. Evaluation of the person shall include verification by a professional,
87.12 after preliminary examination, that the person is intoxicated or has symptoms of substance
87.13 misuse or substance use disorder and appears to be in imminent danger of harming self or
87.14 others. A detoxification program shall have available the services of a licensed physician
87.15 or advanced practice registered nurse for medical emergencies and routine medical
87.16 surveillance. A detoxification program licensed by the Department of Human Services to
87.17 serve both adults and minors at the same site must provide for separate sleeping areas for
87.18 adults and minors.

87.19 Sec. 123. Minnesota Statutes 2018, section 256.9685, subdivision 1a, is amended to read:

87.20 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,
87.21 subdivision 15, the commissioner shall establish an administrative reconsideration process
87.22 for appeals of inpatient hospital services determined to be medically unnecessary. A
87.23 physician, advanced practice registered nurse, or hospital may request a reconsideration of
87.24 the decision that inpatient hospital services are not medically necessary by submitting a
87.25 written request for review to the commissioner within 30 days after receiving notice of the
87.26 decision. The reconsideration process shall take place prior to the procedures of subdivision
87.27 1b and shall be conducted by the medical review agent that is independent of the case under
87.28 reconsideration.

87.29 Sec. 124. Minnesota Statutes 2018, section 256.9685, subdivision 1b, is amended to read:

87.30 Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the
87.31 commissioner may recover inpatient hospital payments for services that have been determined
87.32 to be medically unnecessary after the reconsideration and determinations. A physician,
87.33 advanced practice registered nurse, or hospital may appeal the result of the reconsideration

88.1 process by submitting a written request for review to the commissioner within 30 days after
88.2 receiving notice of the action. The commissioner shall review the medical record and
88.3 information submitted during the reconsideration process and the medical review agent's
88.4 basis for the determination that the services were not medically necessary for inpatient
88.5 hospital services. The commissioner shall issue an order upholding or reversing the decision
88.6 of the reconsideration process based on the review.

88.7 Sec. 125. Minnesota Statutes 2018, section 256.9685, subdivision 1c, is amended to read:

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

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

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

88.18 Sec. 126. Minnesota Statutes 2018, section 256.975, subdivision 7a, is amended to read:

88.19 Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a)
88.20 All individuals seeking admission to Medicaid-certified nursing facilities, including certified
88.21 boarding care facilities, must be screened prior to admission regardless of income, assets,
88.22 or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs
88.23 (a) and (b). The purpose of the screening is to determine the need for nursing facility level
88.24 of care as described in section 256B.0911, subdivision 4e, and to complete activities required
88.25 under federal law related to mental illness and developmental disability as outlined in
88.26 paragraph (b).

88.27 (b) A person who has a diagnosis or possible diagnosis of mental illness or developmental
88.28 disability must receive a preadmission screening before admission regardless of the
88.29 exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further
88.30 evaluation and specialized services, unless the admission prior to screening is authorized
88.31 by the local mental health authority or the local developmental disabilities case manager,
88.32 or unless authorized by the county agency according to Public Law 101-508.

89.1 (c) The following criteria apply to the preadmission screening:

89.2 (1) requests for preadmission screenings must be submitted via an online form developed
89.3 by the commissioner;

89.4 (2) the Senior LinkAge Line must use forms and criteria developed by the commissioner
89.5 to identify persons who require referral for further evaluation and determination of the need
89.6 for specialized services; and

89.7 (3) the evaluation and determination of the need for specialized services must be done
89.8 by:

89.9 (i) a qualified independent mental health professional, for persons with a primary or
89.10 secondary diagnosis of a serious mental illness; or

89.11 (ii) a qualified developmental disability professional, for persons with a primary or
89.12 secondary diagnosis of developmental disability. For purposes of this requirement, a qualified
89.13 developmental disability professional must meet the standards for a qualified developmental
89.14 disability professional under Code of Federal Regulations, title 42, section 483.430.

89.15 (d) The local county mental health authority or the state developmental disability authority
89.16 under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the
89.17 individual does not meet the nursing facility level of care criteria or needs specialized
89.18 services as defined in Public Laws 100-203 and 101-508. For purposes of this section,
89.19 "specialized services" for a person with developmental disability means active treatment as
89.20 that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

89.21 (e) In assessing a person's needs, the screener shall:

89.22 (1) use an automated system designated by the commissioner;

89.23 (2) consult with care transitions coordinators ~~or~~, physician, or advanced practice registered
89.24 nurse; and

89.25 (3) consider the assessment of the individual's physician or advanced practice registered
89.26 nurse.

89.27 Other personnel may be included in the level of care determination as deemed necessary
89.28 by the screener.

89.29 Sec. 127. Minnesota Statutes 2018, section 256.975, subdivision 11, is amended to read:

89.30 Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging
89.31 shall award competitive grants to eligible applicants for regional and local projects and

90.1 initiatives targeted to a designated community, which may consist of a specific geographic
90.2 area or population, to increase awareness of Alzheimer's disease and other dementias,
90.3 increase the rate of cognitive testing in the population at risk for dementias, promote the
90.4 benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to
90.5 education and resources.

90.6 (b) The project areas for grants include:

90.7 (1) local or community-based initiatives to promote the benefits of physician or advanced
90.8 practice registered nurse consultations for all individuals who suspect a memory or cognitive
90.9 problem;

90.10 (2) local or community-based initiatives to promote the benefits of early diagnosis of
90.11 Alzheimer's disease and other dementias; and

90.12 (3) local or community-based initiatives to provide informational materials and other
90.13 resources to caregivers of persons with dementia.

90.14 (c) Eligible applicants for local and regional grants may include, but are not limited to,
90.15 community health boards, school districts, colleges and universities, community clinics,
90.16 tribal communities, nonprofit organizations, and other health care organizations.

90.17 (d) Applicants must:

90.18 (1) describe the proposed initiative, including the targeted community and how the
90.19 initiative meets the requirements of this subdivision; and

90.20 (2) identify the proposed outcomes of the initiative and the evaluation process to be used
90.21 to measure these outcomes.

90.22 (e) In awarding the regional and local dementia grants, the Minnesota Board on Aging
90.23 must give priority to applicants who demonstrate that the proposed project:

90.24 (1) is supported by and appropriately targeted to the community the applicant serves;

90.25 (2) is designed to coordinate with other community activities related to other health
90.26 initiatives, particularly those initiatives targeted at the elderly;

90.27 (3) is conducted by an applicant able to demonstrate expertise in the project areas;

90.28 (4) utilizes and enhances existing activities and resources or involves innovative
90.29 approaches to achieve success in the project areas; and

90.30 (5) strengthens community relationships and partnerships in order to achieve the project
90.31 areas.

91.1 (f) The board shall divide the state into specific geographic regions and allocate a
 91.2 percentage of the money available for the local and regional dementia grants to projects or
 91.3 initiatives aimed at each geographic region.

91.4 (g) The board shall award any available grants by January 1, 2016, and each July 1
 91.5 thereafter.

91.6 (h) Each grant recipient shall report to the board on the progress of the initiative at least
 91.7 once during the grant period, and within two months of the end of the grant period shall
 91.8 submit a final report to the board that includes the outcome results.

91.9 (i) The Minnesota Board on Aging shall:

91.10 (1) develop the criteria and procedures to allocate the grants under this subdivision,
 91.11 evaluate all applicants on a competitive basis and award the grants, and select qualified
 91.12 providers to offer technical assistance to grant applicants and grantees. The selected provider
 91.13 shall provide applicants and grantees assistance with project design, evaluation methods,
 91.14 materials, and training; and

91.15 (2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on
 91.16 the dementia grants programs under this subdivision to the chairs and ranking minority
 91.17 members of the senate and house of representatives committees and divisions with jurisdiction
 91.18 over health finance and policy. The report shall include:

91.19 (i) information on each grant recipient;

91.20 (ii) a summary of all projects or initiatives undertaken with each grant;

91.21 (iii) the measurable outcomes established by each grantee, an explanation of the
 91.22 evaluation process used to determine whether the outcomes were met, and the results of the
 91.23 evaluation; and

91.24 (iv) an accounting of how the grant funds were spent.

91.25 Sec. 128. Minnesota Statutes 2018, section 256B.038, is amended to read:

91.26 **256B.038 PROVIDER RATE INCREASES AFTER JUNE 30, 1999.**

91.27 (a) For fiscal years beginning on or after July 1, 1999, the commissioner of management
 91.28 and budget shall include an annual inflationary adjustment in payment rates for the services
 91.29 listed in paragraph (b) as a budget change request in each biennial detailed expenditure
 91.30 budget submitted to the legislature under section 16A.11. The adjustment shall be
 91.31 accomplished by indexing the rates in effect for inflation based on the change in the
 91.32 Consumer Price Index-All Items (United States city average)(CPI-U) as forecasted by Data

92.1 Resources, Inc., in the fourth quarter of the prior year for the calendar year during which
92.2 the rate increase occurs.

92.3 (b) Within the limits of appropriations specifically for this purpose, the commissioner
92.4 shall apply the rate increases in paragraph (a) to home and community-based waiver services
92.5 for persons with developmental disabilities under section 256B.501; home and
92.6 community-based waiver services for the elderly under section 256B.0915; waived services
92.7 under community access for disability inclusion under section 256B.49; community
92.8 alternative care waived services under section 256B.49; brain injury waived services
92.9 under section 256B.49; nursing services and home health services under section 256B.0625,
92.10 subdivision 6a; personal care services and nursing supervision of personal care services
92.11 under section 256B.0625, subdivision 19a; home care nursing services under section
92.12 256B.0625, subdivision 7; day training and habilitation services for adults with developmental
92.13 disabilities under sections 252.41 to 252.46; physical therapy services under section
92.14 256B.0625, subdivision 8; occupational therapy services under section 256B.0625,
92.15 subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390;
92.16 respiratory therapy services under Minnesota Rules, part 9505.0295; physician or advanced
92.17 practice registered nurse services under section 256B.0625, subdivision 3; dental services
92.18 under section 256B.0625, subdivision 9; alternative care services under section 256B.0913;
92.19 adult residential program grants under section 245.73; adult and family community support
92.20 grants under Minnesota Rules, parts 9535.1700 to 9535.1760; and semi-independent living
92.21 services under section 252.275, including SILS funding under county social services grants
92.22 formerly funded under chapter 256I.

92.23 (c) The commissioner shall increase prepaid medical assistance program capitation rates
92.24 as appropriate to reflect the rate increases in this section.

92.25 (d) In implementing this section, the commissioner shall consider proposing a schedule
92.26 to equalize rates paid by different programs for the same service.

92.27 Sec. 129. Minnesota Statutes 2018, section 256B.04, subdivision 14a, is amended to read:

92.28 Subd. 14a. **Level of need determination.** Nonemergency medical transportation level
92.29 of need determinations must be performed by a physician, a registered nurse working under
92.30 direct supervision of a physician, a physician assistant, ~~a nurse practitioner~~ an advanced
92.31 practice registered nurse, a licensed practical nurse, or a discharge planner. Nonemergency
92.32 medical transportation level of need determinations must not be performed more than
92.33 annually on any individual, unless the individual's circumstances have sufficiently changed
92.34 so as to require a new level of need determination. Individuals residing in licensed nursing

93.1 facilities are exempt from a level of need determination and are eligible for special
 93.2 transportation services until the individual no longer resides in a licensed nursing facility.
 93.3 If a person authorized by this subdivision to perform a level of need determination determines
 93.4 that an individual requires stretcher transportation, the individual is presumed to maintain
 93.5 that level of need until otherwise determined by a person authorized to perform a level of
 93.6 need determination, or for six months, whichever is sooner.

93.7 Sec. 130. Minnesota Statutes 2018, section 256B.043, subdivision 2, is amended to read:

93.8 Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part
 93.9 of their ongoing duties, shall consider the adequacy of the current system of community
 93.10 health clinics and centers both statewide and in urban areas with significant disparities in
 93.11 health status and access to services across racial and ethnic groups, including:

93.12 (1) methods to provide 24-hour availability of care through the clinics and centers;

93.13 (2) methods to expand the availability of care through the clinics and centers;

93.14 (3) the use of grants to expand the number of clinics and centers, the services provided,
 93.15 and the availability of care; and

93.16 (4) the extent to which increased use of physician assistants, ~~nurse practitioners~~ advanced
 93.17 practice registered nurses, medical residents and interns, and other allied health professionals
 93.18 in clinics and centers would increase the availability of services.

93.19 (b) The commissioners shall make departmental modifications and legislative
 93.20 recommendations as appropriate on the basis of their considerations under paragraph (a).

93.21 Sec. 131. Minnesota Statutes 2018, section 256B.055, subdivision 12, is amended to read:

93.22 Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if
 93.23 the person is under age 19 and qualifies as a disabled individual under United States Code,
 93.24 title 42, section 1382c(a), and would be eligible for medical assistance under the state plan
 93.25 if residing in a medical institution, and the child requires a level of care provided in a hospital,
 93.26 nursing facility, or intermediate care facility for persons with developmental disabilities,
 93.27 for whom home care is appropriate, provided that the cost to medical assistance under this
 93.28 section is not more than the amount that medical assistance would pay for if the child resides
 93.29 in an institution. After the child is determined to be eligible under this section, the
 93.30 commissioner shall review the child's disability under United States Code, title 42, section
 93.31 1382c(a) and level of care defined under this section no more often than annually and may
 93.32 elect, based on the recommendation of health care professionals under contract with the

94.1 state medical review team, to extend the review of disability and level of care up to a
94.2 maximum of four years. The commissioner's decision on the frequency of continuing review
94.3 of disability and level of care is not subject to administrative appeal under section 256.045.
94.4 The county agency shall send a notice of disability review to the enrollee six months prior
94.5 to the date the recertification of disability is due. Nothing in this subdivision shall be
94.6 construed as affecting other redeterminations of medical assistance eligibility under this
94.7 chapter and annual cost-effective reviews under this section.

94.8 (b) For purposes of this subdivision, "hospital" means an institution as defined in section
94.9 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and
94.10 licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child
94.11 requires a level of care provided in a hospital if the child is determined by the commissioner
94.12 to need an extensive array of health services, including mental health services, for an
94.13 undetermined period of time, whose health condition requires frequent monitoring and
94.14 treatment by a health care professional or by a person supervised by a health care
94.15 professional, who would reside in a hospital or require frequent hospitalization if these
94.16 services were not provided, and the daily care needs are more complex than a nursing facility
94.17 level of care.

94.18 A child with serious emotional disturbance requires a level of care provided in a hospital
94.19 if the commissioner determines that the individual requires 24-hour supervision because
94.20 the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent
94.21 or frequent psychosomatic disorders or somatopsychic disorders that may become life
94.22 threatening, recurrent or frequent severe socially unacceptable behavior associated with
94.23 psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic
94.24 developmental problems requiring continuous skilled observation, or severe disabling
94.25 symptoms for which office-centered outpatient treatment is not adequate, and which overall
94.26 severely impact the individual's ability to function.

94.27 (c) For purposes of this subdivision, "nursing facility" means a facility which provides
94.28 nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections
94.29 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is
94.30 in need of special treatments provided or supervised by a licensed nurse; or has unpredictable
94.31 episodes of active disease processes requiring immediate judgment by a licensed nurse. For
94.32 purposes of this subdivision, a child requires the level of care provided in a nursing facility
94.33 if the child is determined by the commissioner to meet the requirements of the preadmission
94.34 screening assessment document under section 256B.0911, adjusted to address age-appropriate
94.35 standards for children age 18 and under.

95.1 (d) For purposes of this subdivision, "intermediate care facility for persons with
95.2 developmental disabilities" or "ICF/DD" means a program licensed to provide services to
95.3 persons with developmental disabilities under section 252.28, and chapter 245A, and a
95.4 physical plant licensed as a supervised living facility under chapter 144, which together are
95.5 certified by the Minnesota Department of Health as meeting the standards in Code of Federal
95.6 Regulations, title 42, part 483, for an intermediate care facility which provides services for
95.7 persons with developmental disabilities who require 24-hour supervision and active treatment
95.8 for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child
95.9 requires a level of care provided in an ICF/DD if the commissioner finds that the child has
95.10 a developmental disability in accordance with section 256B.092, is in need of a 24-hour
95.11 plan of care and active treatment similar to persons with developmental disabilities, and
95.12 there is a reasonable indication that the child will need ICF/DD services.

95.13 (e) For purposes of this subdivision, a person requires the level of care provided in a
95.14 nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental
95.15 health treatment because of specific symptoms or functional impairments associated with
95.16 a serious mental illness or disorder diagnosis, which meet severity criteria for mental health
95.17 established by the commissioner and published in March 1997 as the Minnesota Mental
95.18 Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

95.19 (f) The determination of the level of care needed by the child shall be made by the
95.20 commissioner based on information supplied to the commissioner by the parent or guardian,
95.21 the child's physician or physicians or advanced practice registered nurse or advanced practice
95.22 registered nurses, and other professionals as requested by the commissioner. The
95.23 commissioner shall establish a screening team to conduct the level of care determinations
95.24 according to this subdivision.

95.25 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
95.26 must assess the case to determine whether:

95.27 (1) the child qualifies as a disabled individual under United States Code, title 42, section
95.28 1382c(a), and would be eligible for medical assistance if residing in a medical institution;
95.29 and

95.30 (2) the cost of medical assistance services for the child, if eligible under this subdivision,
95.31 would not be more than the cost to medical assistance if the child resides in a medical
95.32 institution to be determined as follows:

96.1 (i) for a child who requires a level of care provided in an ICF/DD, the cost of care for
96.2 the child in an institution shall be determined using the average payment rate established
96.3 for the regional treatment centers that are certified as ICF's/DD;

96.4 (ii) for a child who requires a level of care provided in an inpatient hospital setting
96.5 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
96.6 Rules, part 9505.3520, items F and G; and

96.7 (iii) for a child who requires a level of care provided in a nursing facility according to
96.8 paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules,
96.9 part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates
96.10 which would be paid for children under age 16. The commissioner may authorize an amount
96.11 up to the amount medical assistance would pay for a child referred to the commissioner by
96.12 the preadmission screening team under section 256B.0911.

96.13 Sec. 132. Minnesota Statutes 2018, section 256B.0622, subdivision 2b, is amended to
96.14 read:

96.15 Subd. 2b. **Continuing stay and discharge criteria for assertive community**
96.16 **treatment.** (a) A client receiving assertive community treatment is eligible to continue
96.17 receiving services if:

96.18 (1) the client has not achieved the desired outcomes of their individual treatment plan;

96.19 (2) the client's level of functioning has not been restored, improved, or sustained over
96.20 the time frame outlined in the individual treatment plan;

96.21 (3) the client continues to be at risk for relapse based on current clinical assessment,
96.22 history, or the tenuous nature of the functional gains; or

96.23 (4) the client is functioning effectively with this service and discharge would otherwise
96.24 be indicated but without continued services the client's functioning would decline; and

96.25 (5) one of the following must also apply:

96.26 (i) the client has achieved current individual treatment plan goals but additional goals
96.27 are indicated as evidenced by documented symptoms;

96.28 (ii) the client is making satisfactory progress toward meeting goals and there is
96.29 documentation that supports that continuation of this service shall be effective in addressing
96.30 the goals outlined in the individual treatment plan;

97.1 (iii) the client is making progress, but the specific interventions in the individual treatment
97.2 plan need to be modified so that greater gains, which are consistent with the client's potential
97.3 level of functioning, are possible; or

97.4 (iv) the client fails to make progress or demonstrates regression in meeting goals through
97.5 the interventions outlined in the individual treatment plan.

97.6 (b) Clients receiving assertive community treatment are eligible to be discharged if they
97.7 meet at least one of the following criteria:

97.8 (1) the client and the ACT team determine that assertive community treatment services
97.9 are no longer needed based on the attainment of goals as identified in the individual treatment
97.10 plan and a less intensive level of care would adequately address current goals;

97.11 (2) the client moves out of the ACT team's service area and the ACT team has facilitated
97.12 the referral to either a new ACT team or other appropriate mental health service and has
97.13 assisted the individual in the transition process;

97.14 (3) the client, or the client's legal guardian when applicable, chooses to withdraw from
97.15 assertive community treatment services and documented attempts by the ACT team to
97.16 re-engage the client with the service have not been successful;

97.17 (4) the client has a demonstrated need for a medical nursing home placement lasting
97.18 more than three months, as determined by a physician or advanced practice registered nurse;

97.19 (5) the client is hospitalized, in residential treatment, or in jail for a period of greater
97.20 than three months. However, the ACT team must make provisions for the client to return
97.21 to the ACT team upon their discharge or release from the hospital or jail if the client still
97.22 meets eligibility criteria for assertive community treatment and the team is not at full capacity;

97.23 (6) the ACT team is unable to locate, contact, and engage the client for a period of greater
97.24 than three months after persistent efforts by the ACT team to locate the client; or

97.25 (7) the client requests a discharge, despite repeated and proactive efforts by the ACT
97.26 team to engage the client in service planning. The ACT team must develop a transition plan
97.27 to arrange for alternate treatment for clients in this situation who have a history of suicide
97.28 attempts, assault, or forensic involvement.

97.29 (c) For all clients who are discharged from assertive community treatment to another
97.30 service provider within the ACT team's service area there is a three-month transfer period,
97.31 from the date of discharge, during which a client who does not adjust well to the new service,
97.32 may voluntarily return to the ACT team. During this period, the ACT team must maintain
97.33 contact with the client's new service provider.

98.1 Sec. 133. Minnesota Statutes 2018, section 256B.0622, subdivision 8, is amended to read:

98.2 Subd. 8. **Medical assistance payment for assertive community treatment and**
98.3 **intensive residential treatment services.** (a) Payment for intensive residential treatment
98.4 services and assertive community treatment in this section shall be based on one daily rate
98.5 per provider inclusive of the following services received by an eligible client in a given
98.6 calendar day: all rehabilitative services under this section, staff travel time to provide
98.7 rehabilitative services under this section, and nonresidential crisis stabilization services
98.8 under section 256B.0624.

98.9 (b) Except as indicated in paragraph (c), payment will not be made to more than one
98.10 entity for each client for services provided under this section on a given day. If services
98.11 under this section are provided by a team that includes staff from more than one entity, the
98.12 team must determine how to distribute the payment among the members.

98.13 (c) The commissioner shall determine one rate for each provider that will bill medical
98.14 assistance for residential services under this section and one rate for each assertive community
98.15 treatment provider. If a single entity provides both services, one rate is established for the
98.16 entity's residential services and another rate for the entity's nonresidential services under
98.17 this section. A provider is not eligible for payment under this section without authorization
98.18 from the commissioner. The commissioner shall develop rates using the following criteria:

98.19 (1) the provider's cost for services shall include direct services costs, other program
98.20 costs, and other costs determined as follows:

98.21 (i) the direct services costs must be determined using actual costs of salaries, benefits,
98.22 payroll taxes, and training of direct service staff and service-related transportation;

98.23 (ii) other program costs not included in item (i) must be determined as a specified
98.24 percentage of the direct services costs as determined by item (i). The percentage used shall
98.25 be determined by the commissioner based upon the average of percentages that represent
98.26 the relationship of other program costs to direct services costs among the entities that provide
98.27 similar services;

98.28 (iii) physical plant costs calculated based on the percentage of space within the program
98.29 that is entirely devoted to treatment and programming. This does not include administrative
98.30 or residential space;

98.31 (iv) assertive community treatment physical plant costs must be reimbursed as part of
98.32 the costs described in item (ii); and

99.1 (v) subject to federal approval, up to an additional five percent of the total rate may be
99.2 added to the program rate as a quality incentive based upon the entity meeting performance
99.3 criteria specified by the commissioner;

99.4 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
99.5 consistent with federal reimbursement requirements under Code of Federal Regulations,
99.6 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
99.7 Budget Circular Number A-122, relating to nonprofit entities;

99.8 (3) the number of service units;

99.9 (4) the degree to which clients will receive services other than services under this section;
99.10 and

99.11 (5) the costs of other services that will be separately reimbursed.

99.12 (d) The rate for intensive residential treatment services and assertive community treatment
99.13 must exclude room and board, as defined in section 256I.03, subdivision 6, and services
99.14 not covered under this section, such as partial hospitalization, home care, and inpatient
99.15 services.

99.16 (e) Physician or advanced practice registered nurse services that are not separately billed
99.17 may be included in the rate to the extent that a psychiatrist, or other health care professional
99.18 providing physician or advanced practice registered nurse services within their scope of
99.19 practice, is a member of the intensive residential treatment services treatment team. Physician
99.20 or advanced practice registered nurse services, whether billed separately or included in the
99.21 rate, may be delivered by telemedicine. For purposes of this paragraph, "telemedicine" has
99.22 the meaning given to "mental health telemedicine" in section 256B.0625, subdivision 46,
99.23 when telemedicine is used to provide intensive residential treatment services.

99.24 (f) When services under this section are provided by an assertive community treatment
99.25 provider, case management functions must be an integral part of the team.

99.26 (g) The rate for a provider must not exceed the rate charged by that provider for the
99.27 same service to other payors.

99.28 (h) The rates for existing programs must be established prospectively based upon the
99.29 expenditures and utilization over a prior 12-month period using the criteria established in
99.30 paragraph (c). The rates for new programs must be established based upon estimated
99.31 expenditures and estimated utilization using the criteria established in paragraph (c).

99.32 (i) Entities who discontinue providing services must be subject to a settle-up process
99.33 whereby actual costs and reimbursement for the previous 12 months are compared. In the

100.1 event that the entity was paid more than the entity's actual costs plus any applicable
100.2 performance-related funding due the provider, the excess payment must be reimbursed to
100.3 the department. If a provider's revenue is less than actual allowed costs due to lower
100.4 utilization than projected, the commissioner may reimburse the provider to recover its actual
100.5 allowable costs. The resulting adjustments by the commissioner must be proportional to the
100.6 percent of total units of service reimbursed by the commissioner and must reflect a difference
100.7 of greater than five percent.

100.8 (j) A provider may request of the commissioner a review of any rate-setting decision
100.9 made under this subdivision.

100.10 Sec. 134. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

100.11 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
100.12 given them.

100.13 (a) "Adult rehabilitative mental health services" means mental health services which are
100.14 rehabilitative and enable the recipient to develop and enhance psychiatric stability, social
100.15 competencies, personal and emotional adjustment, independent living, parenting skills, and
100.16 community skills, when these abilities are impaired by the symptoms of mental illness.
100.17 Adult rehabilitative mental health services are also appropriate when provided to enable a
100.18 recipient to retain stability and functioning, if the recipient would be at risk of significant
100.19 functional decompensation or more restrictive service settings without these services.

100.20 (1) Adult rehabilitative mental health services instruct, assist, and support the recipient
100.21 in areas such as: interpersonal communication skills, community resource utilization and
100.22 integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting
100.23 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
100.24 transportation skills, medication education and monitoring, mental illness symptom
100.25 management skills, household management skills, employment-related skills, parenting
100.26 skills, and transition to community living services.

100.27 (2) These services shall be provided to the recipient on a one-to-one basis in the recipient's
100.28 home or another community setting or in groups.

100.29 (b) "Medication education services" means services provided individually or in groups
100.30 which focus on educating the recipient about mental illness and symptoms; the role and
100.31 effects of medications in treating symptoms of mental illness; and the side effects of
100.32 medications. Medication education is coordinated with medication management services

101.1 and does not duplicate it. Medication education services are provided by physicians, advanced
101.2 practice registered nurses, pharmacists, physician assistants, or registered nurses.

101.3 (c) "Transition to community living services" means services which maintain continuity
101.4 of contact between the rehabilitation services provider and the recipient and which facilitate
101.5 discharge from a hospital, residential treatment program under Minnesota Rules, chapter
101.6 9505, board and lodging facility, or nursing home. Transition to community living services
101.7 are not intended to provide other areas of adult rehabilitative mental health services.

101.8 Sec. 135. Minnesota Statutes 2018, section 256B.0625, subdivision 3, is amended to read:

101.9 Subd. 3. **Physicians' and advanced practice registered nurses' services.** (a) Medical
101.10 assistance covers physicians' and advanced practice registered nurses' services.

101.11 (b) Rates paid for anesthesiology services provided by physicians shall be according to
101.12 the formula utilized in the Medicare program and shall use a conversion factor "at percentile
101.13 of calendar year set by legislature, "except that rates paid to physicians for the medical
101.14 direction of a certified registered nurse anesthetist shall be the same as the rate paid to the
101.15 certified registered nurse anesthetist under medical direction.

101.16 (c) Medical assistance does not cover physicians' and advanced practice registered nurses'
101.17 services related to the provision of care related to a treatment reportable under section
101.18 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

101.19 (d) Medical assistance does not cover physicians' and advanced practice registered nurses'
101.20 services related to the provision of care (1) for which hospital reimbursement is prohibited
101.21 under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section
101.22 144.7065, subdivisions 2 to 7, if the physicians' or advanced practice registered nurses'
101.23 services are billed by a physician or advanced practice registered nurse who delivered care
101.24 that contributed to or caused the adverse health care event or hospital-acquired condition.

101.25 (e) The payment limitations in this subdivision shall also apply to MinnesotaCare.

101.26 (f) A physician or advanced practice registered nurse shall not bill a recipient of services
101.27 for any payment disallowed under this subdivision.

101.28 Sec. 136. Minnesota Statutes 2018, section 256B.0625, subdivision 4, is amended to read:

101.29 Subd. 4. **Outpatient and physician- or advanced practice registered nurse-directed**
101.30 **clinic services.** Medical assistance covers outpatient hospital or physician- or advanced
101.31 practice registered nurse-directed clinic services. The physician- or advanced practice
101.32 registered nurse-directed clinic staff shall include at least two physicians or advanced practice

102.1 registered nurses and all services shall be provided under the direct supervision of a physician
102.2 or advanced practice registered nurse. Hospital outpatient departments are subject to the
102.3 same limitations and reimbursements as other enrolled vendors for all services, except initial
102.4 triage, emergency services, and services not provided or immediately available in clinics,
102.5 physicians' or advanced practice registered nurses' offices, or by other enrolled providers.
102.6 "Emergency services" means those medical services required for the immediate diagnosis
102.7 and treatment of medical conditions that, if not immediately diagnosed and treated, could
102.8 lead to serious physical or mental disability or death or are necessary to alleviate severe
102.9 pain. Neither the hospital, its employees, nor any physician, advanced practice registered
102.10 nurse, or dentist, shall be liable in any action arising out of a determination not to render
102.11 emergency services or care if reasonable care is exercised in determining the condition of
102.12 the person, or in determining the appropriateness of the facilities, or the qualifications and
102.13 availability of personnel to render these services consistent with this section.

102.14 Sec. 137. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to
102.15 read:

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

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

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

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

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

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

103.5 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
103.6 a licensed practitioner or by a licensed pharmacist who meets standards established by the
103.7 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
103.8 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
103.9 with documented vitamin deficiencies, vitamins for children under the age of seven and
103.10 pregnant or nursing women, and any other over-the-counter drug identified by the
103.11 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
103.12 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
103.13 disorders, and this determination shall not be subject to the requirements of chapter 14. A
103.14 pharmacist may prescribe over-the-counter medications as provided under this paragraph
103.15 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
103.16 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
103.17 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
103.18 and make referrals as needed to other health care professionals. Over-the-counter medications
103.19 must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained
103.20 in the manufacturer's original package; (2) the number of dosage units required to complete
103.21 the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed
103.22 from a system using retrospective billing, as provided under subdivision 13e, paragraph
103.23 (b).

103.24 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
103.25 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
103.26 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
103.27 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
103.28 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
103.29 individuals, medical assistance may cover drugs from the drug classes listed in United States
103.30 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
103.31 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
103.32 not be covered.

103.33 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
103.34 Program and dispensed by 340B covered entities and ambulatory pharmacies under common

104.1 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
104.2 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

104.3 Sec. 138. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to
104.4 read:

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

104.9 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
104.10 emergency medical care or transportation costs incurred by eligible persons in obtaining
104.11 emergency or nonemergency medical care when paid directly to an ambulance company,
104.12 nonemergency medical transportation company, or other recognized providers of
104.13 transportation services. Medical transportation must be provided by:

104.14 (1) nonemergency medical transportation providers who meet the requirements of this
104.15 subdivision;

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

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

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

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

104.20 (c) Medical assistance covers nonemergency medical transportation provided by
104.21 nonemergency medical transportation providers enrolled in the Minnesota health care
104.22 programs. All nonemergency medical transportation providers must comply with the
104.23 operating standards for special transportation service as defined in sections 174.29 to 174.30
104.24 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of
104.25 Transportation. All nonemergency medical transportation providers shall bill for
104.26 nonemergency medical transportation services in accordance with Minnesota health care
104.27 programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles
104.28 are exempt from the requirements outlined in this paragraph.

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

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

105.1 (2) the provider has initiated background studies on the individuals specified in section
105.2 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

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

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

106.1 Nonemergency medical transportation providers may not bill for separate base rates for
106.2 the continuation of a trip beyond the original destination. Nonemergency medical
106.3 transportation providers must maintain trip logs, which include pickup and drop-off times,
106.4 signed by the medical provider or client, whichever is deemed most appropriate, attesting
106.5 to mileage traveled to obtain covered medical services. Clients requesting client mileage
106.6 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
106.7 services.

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

106.13 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

107.9 (k) The commissioner shall:

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

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

107.13 (3) investigate all complaints and appeals.

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

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

107.23 (1) \$0.22 per mile for client reimbursement;

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

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

107.29 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

107.30 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

107.31 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

108.1 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
108.2 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

108.20 Sec. 139. Minnesota Statutes 2018, section 256B.0625, subdivision 26, is amended to
108.21 read:

108.22 **Subd. 26. Special education services.** (a) Medical assistance covers evaluations necessary
108.23 in making a determination for eligibility for individualized education program and
108.24 individualized family service plan services and for medical services identified in a recipient's
108.25 individualized education program and individualized family service plan and covered under
108.26 the medical assistance state plan. Covered services include occupational therapy, physical
108.27 therapy, speech-language therapy, clinical psychological services, nursing services, school
108.28 psychological services, school social work services, personal care assistants serving as
108.29 management aides, assistive technology devices, transportation services, health assessments,
108.30 and other services covered under the medical assistance state plan. Mental health services
108.31 eligible for medical assistance reimbursement must be provided or coordinated through a
108.32 children's mental health collaborative where a collaborative exists if the child is included

109.1 in the collaborative operational target population. The provision or coordination of services
109.2 does not require that the individualized education program be developed by the collaborative.

109.3 The services may be provided by a Minnesota school district that is enrolled as a medical
109.4 assistance provider or its subcontractor, and only if the services meet all the requirements
109.5 otherwise applicable if the service had been provided by a provider other than a school
109.6 district, in the following areas: medical necessity, physician's or advanced practice registered
109.7 nurse's orders, documentation, personnel qualifications, and prior authorization requirements.
109.8 The nonfederal share of costs for services provided under this subdivision is the responsibility
109.9 of the local school district as provided in section 125A.74. Services listed in a child's
109.10 individualized education program are eligible for medical assistance reimbursement only
109.11 if those services meet criteria for federal financial participation under the Medicaid program.

109.12 (b) Approval of health-related services for inclusion in the individualized education
109.13 program does not require prior authorization for purposes of reimbursement under this
109.14 chapter. The commissioner may require physician or advanced practice registered nurse
109.15 review and approval of the plan not more than once annually or upon any modification of
109.16 the individualized education program that reflects a change in health-related services.

109.17 (c) Services of a speech-language pathologist provided under this section are covered
109.18 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

109.19 (1) holds a masters degree in speech-language pathology;

109.20 (2) is licensed by the Professional Educator Licensing and Standards Board as an
109.21 educational speech-language pathologist; and

109.22 (3) either has a certificate of clinical competence from the American Speech and Hearing
109.23 Association, has completed the equivalent educational requirements and work experience
109.24 necessary for the certificate or has completed the academic program and is acquiring
109.25 supervised work experience to qualify for the certificate.

109.26 (d) Medical assistance coverage for medically necessary services provided under other
109.27 subdivisions in this section may not be denied solely on the basis that the same or similar
109.28 services are covered under this subdivision.

109.29 (e) The commissioner shall develop and implement package rates, bundled rates, or per
109.30 diem rates for special education services under which separately covered services are grouped
109.31 together and billed as a unit in order to reduce administrative complexity.

109.32 (f) The commissioner shall develop a cost-based payment structure for payment of these
109.33 services. Only costs reported through the designated Minnesota Department of Education

110.1 data systems in distinct service categories qualify for inclusion in the cost-based payment
 110.2 structure. The commissioner shall reimburse claims submitted based on an interim rate, and
 110.3 shall settle at a final rate once the department has determined it. The commissioner shall
 110.4 notify the school district of the final rate. The school district has 60 days to appeal the final
 110.5 rate. To appeal the final rate, the school district shall file a written appeal request to the
 110.6 commissioner within 60 days of the date the final rate determination was mailed. The appeal
 110.7 request shall specify (1) the disputed items and (2) the name and address of the person to
 110.8 contact regarding the appeal.

110.9 (g) Effective July 1, 2000, medical assistance services provided under an individualized
 110.10 education program or an individual family service plan by local school districts shall not
 110.11 count against medical assistance authorization thresholds for that child.

110.12 (h) Nursing services as defined in section 148.171, subdivision 15, and provided as an
 110.13 individualized education program health-related service, are eligible for medical assistance
 110.14 payment if they are otherwise a covered service under the medical assistance program.
 110.15 Medical assistance covers the administration of prescription medications by a licensed nurse
 110.16 who is employed by or under contract with a school district when the administration of
 110.17 medications is identified in the child's individualized education program. The simple
 110.18 administration of medications alone is not covered under medical assistance when
 110.19 administered by a provider other than a school district or when it is not identified in the
 110.20 child's individualized education program.

110.21 Sec. 140. Minnesota Statutes 2018, section 256B.0625, subdivision 28, is amended to
 110.22 read:

110.23 Subd. 28. ~~Certified nurse practitioner~~ **Advanced practice registered nurse**
 110.24 **services.** Medical assistance covers services performed by a certified pediatric nurse
 110.25 ~~practitioner~~ advanced practice registered nurse, a certified family ~~nurse practitioner~~ advanced
 110.26 practice registered nurse, a certified adult ~~nurse practitioner~~ advanced practice registered
 110.27 nurse, a certified obstetric/gynecological ~~nurse practitioner~~ advanced practice registered
 110.28 nurse, a certified neonatal ~~nurse practitioner~~ advanced practice registered nurse, or a certified
 110.29 geriatric ~~nurse practitioner~~ advanced practice registered nurse in independent practice, if:

110.30 (1) the service provided on an inpatient basis is not included as part of the cost for
 110.31 inpatient services included in the operating payment rate;

110.32 (2) the service is otherwise covered under this chapter as a physician service; and

111.1 (3) the service is within the scope of practice of the ~~nurse-practitioner's~~ advanced practice
111.2 registered nurse's license as a registered nurse, as defined in section 148.171.

111.3 Sec. 141. Minnesota Statutes 2018, section 256B.0625, subdivision 60a, is amended to
111.4 read:

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

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

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

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

111.14 (3) medication access confirmation;

111.15 (4) food access confirmation; and

111.16 (5) identification of home hazards.

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

111.21 (1) medication access confirmation;

111.22 (2) food access confirmation; and

111.23 (3) identification of home hazards.

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

111.26 Sec. 142. Minnesota Statutes 2018, section 256B.0654, subdivision 1, is amended to read:

111.27 Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing
111.28 services provided to recipients who meet the criteria for regular home care nursing and
111.29 require life-sustaining interventions to reduce the risk of long-term injury or death.

112.1 (b) "Home care nursing" means ongoing ~~physician-ordered~~ hourly nursing ordered by
 112.2 a physician or advanced practice registered nurse and services performed by a registered
 112.3 nurse or licensed practical nurse within the scope of practice as defined by the Minnesota
 112.4 Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a
 112.5 person's health.

112.6 (c) "Home care nursing agency" means a medical assistance enrolled provider licensed
 112.7 under chapter 144A to provide home care nursing services.

112.8 (d) "Regular home care nursing" means home care nursing provided because:

112.9 (1) the recipient requires more individual and continuous care than can be provided
 112.10 during a skilled nurse visit; or

112.11 (2) the cares are outside of the scope of services that can be provided by a home health
 112.12 aide or personal care assistant.

112.13 (e) "Shared home care nursing" means the provision of home care nursing services by
 112.14 a home care nurse to two recipients at the same time and in the same setting.

112.15 Sec. 143. Minnesota Statutes 2018, section 256B.0654, subdivision 2a, is amended to
 112.16 read:

112.17 Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

112.18 (1) in the recipient's home or outside the home when normal life activities require;

112.19 (2) when the recipient requires more individual and continuous care than can be provided
 112.20 during a skilled nurse visit; and

112.21 (3) when the care required is outside of the scope of services that can be provided by a
 112.22 home health aide or personal care assistant.

112.23 (b) Home care nursing services must be:

112.24 (1) assessed by a registered nurse on a form approved by the commissioner;

112.25 (2) ordered by a physician or advanced practice registered nurse and documented in a
 112.26 plan of care that is reviewed by the physician at least once every 60 days; and

112.27 (3) authorized by the commissioner under section 256B.0652.

112.28 Sec. 144. Minnesota Statutes 2018, section 256B.0654, subdivision 3, is amended to read:

112.29 Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared
 112.30 home care nursing services by a home care nurse shall be limited according to this

113.1 subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory
113.2 provisions relating to home care nursing services apply to shared home care nursing services.
113.3 Nothing in this subdivision shall be construed to reduce the total number of home care
113.4 nursing hours authorized for an individual recipient.

113.5 (b) Shared home care nursing is the provision of nursing services by a home care nurse
113.6 to two medical assistance eligible recipients at the same time and in the same setting. This
113.7 subdivision does not apply when a home care nurse is caring for multiple recipients in more
113.8 than one setting.

113.9 (c) For the purposes of this subdivision, "setting" means:

113.10 (1) the home residence or foster care home of one of the individual recipients as defined
113.11 in section 256B.0651;

113.12 (2) a child care program licensed under chapter 245A or operated by a local school
113.13 district or private school;

113.14 (3) an adult day care service licensed under chapter 245A; or

113.15 (4) outside the home residence or foster care home of one of the recipients when normal
113.16 life activities take the recipients outside the home.

113.17 (d) The home care nursing agency must offer the recipient the option of shared or
113.18 one-on-one home care nursing services. The recipient may withdraw from participating in
113.19 a shared service arrangement at any time.

113.20 (e) The recipient or the recipient's legal representative, and the recipient's physician or
113.21 advanced practice registered nurse, in conjunction with the home care nursing agency, shall
113.22 determine:

113.23 (1) whether shared home care nursing care is an appropriate option based on the individual
113.24 needs and preferences of the recipient; and

113.25 (2) the amount of shared home care nursing services authorized as part of the overall
113.26 authorization of nursing services.

113.27 (f) The recipient or the recipient's legal representative, in conjunction with the home
113.28 care nursing agency, shall approve the setting, grouping, and arrangement of shared home
113.29 care nursing care based on the individual needs and preferences of the recipients. Decisions
113.30 on the selection of recipients to share services must be based on the ages of the recipients,
113.31 compatibility, and coordination of their care needs.

114.1 (g) The following items must be considered by the recipient or the recipient's legal
114.2 representative and the home care nursing agency, and documented in the recipient's health
114.3 service record:

114.4 (1) the additional training needed by the home care nurse to provide care to two recipients
114.5 in the same setting and to ensure that the needs of the recipients are met appropriately and
114.6 safely;

114.7 (2) the setting in which the shared home care nursing care will be provided;

114.8 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of
114.9 the service and process used to make changes in service or setting;

114.10 (4) a contingency plan which accounts for absence of the recipient in a shared home
114.11 care nursing setting due to illness or other circumstances;

114.12 (5) staffing backup contingencies in the event of employee illness or absence; and

114.13 (6) arrangements for additional assistance to respond to urgent or emergency care needs
114.14 of the recipients.

114.15 (h) The documentation for shared home care nursing must be on a form approved by
114.16 the commissioner for each individual recipient sharing home care nursing. The documentation
114.17 must be part of the recipient's health service record and include:

114.18 (1) permission by the recipient or the recipient's legal representative for the maximum
114.19 number of shared nursing hours per week chosen by the recipient and permission for shared
114.20 home care nursing services provided in and outside the recipient's home residence;

114.21 (2) revocation by the recipient or the recipient's legal representative for the shared home
114.22 care nursing permission, or services provided to others in and outside the recipient's
114.23 residence; and

114.24 (3) daily documentation of the shared home care nursing services provided by each
114.25 identified home care nurse, including:

114.26 (i) the names of each recipient receiving shared home care nursing services;

114.27 (ii) the setting for the shared services, including the starting and ending times that the
114.28 recipient received shared home care nursing care; and

114.29 (iii) notes by the home care nurse regarding changes in the recipient's condition, problems
114.30 that may arise from the sharing of home care nursing services, and scheduling and care
114.31 issues.

115.1 (i) The commissioner shall provide a rate methodology for shared home care nursing.
115.2 For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times
115.3 the regular home care nursing rates paid for serving a single individual by a registered nurse
115.4 or licensed practical nurse. These rates apply only to situations in which both recipients are
115.5 present and receive shared home care nursing care on the date for which the service is billed.

115.6 Sec. 145. Minnesota Statutes 2018, section 256B.0654, subdivision 4, is amended to read:

115.7 Subd. 4. **Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary
115.8 services that require specialized nursing skills and are provided by parents of minor children,
115.9 family foster parents, spouses, and legal guardians who are providing home care nursing
115.10 care under the following conditions:

115.11 (1) the provision of these services is not legally required of the parents, spouses, or legal
115.12 guardians;

115.13 (2) the services are necessary to prevent hospitalization of the recipient; and

115.14 (3) the recipient is eligible for state plan home care or a home and community-based
115.15 waiver and one of the following hardship criteria are met:

115.16 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
115.17 provide nursing care for the recipient;

115.18 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
115.19 less compensation to provide nursing care for the recipient;

115.20 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide
115.21 nursing care for the recipient; or

115.22 (iv) because of labor conditions, special language needs, or intermittent hours of care
115.23 needed, the parent, spouse, or legal guardian is needed in order to provide adequate home
115.24 care nursing services to meet the medical needs of the recipient.

115.25 (b) Home care nursing may be provided by a parent, spouse, family foster parent, or
115.26 legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided
115.27 by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing
115.28 services covered and available under liable third-party payors, including Medicare. The
115.29 home care nursing provided by a parent, spouse, family foster parent, or legal guardian must
115.30 be included in the service agreement. Authorized nursing services for a single recipient or
115.31 recipients with the same residence and provided by the parent, spouse, family foster parent,
115.32 or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight

116.1 hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents,
116.2 spouse, family foster parent, or legal guardian shall not provide more than 40 hours of
116.3 services in a seven-day period. For parents, family foster parents, and legal guardians, 40
116.4 hours is the total amount allowed regardless of the number of children or adults who receive
116.5 services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's
116.6 obligation of assuming the nonreimbursed family responsibilities of emergency backup
116.7 caregiver and primary caregiver.

116.8 (c) A parent, family foster parent, or a spouse may not be paid to provide home care
116.9 nursing care if:

116.10 (1) the parent or spouse fails to pass a criminal background check according to chapter
116.11 245C;

116.12 (2) it has been determined by the home care nursing agency, the case manager, or the
116.13 physician or advanced practice registered nurse that the home care nursing provided by the
116.14 parent, family foster parent, spouse, or legal guardian is unsafe; or

116.15 (3) the parent, family foster parent, spouse, or legal guardian does not follow physician
116.16 or advanced practice registered nurse orders.

116.17 (d) For purposes of this section, "assessment" means a review and evaluation of a
116.18 recipient's need for home care services conducted in person. Assessments for home care
116.19 nursing must be conducted by a registered nurse.

116.20 Sec. 146. Minnesota Statutes 2018, section 256B.0659, subdivision 2, is amended to read:

116.21 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
116.22 assistance services eligible for payment include services and supports furnished to an
116.23 individual, as needed, to assist in:

116.24 (1) activities of daily living;

116.25 (2) health-related procedures and tasks;

116.26 (3) observation and redirection of behaviors; and

116.27 (4) instrumental activities of daily living.

116.28 (b) Activities of daily living include the following covered services:

116.29 (1) dressing, including assistance with choosing, application, and changing of clothing
116.30 and application of special appliances, wraps, or clothing;

117.1 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
117.2 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
117.3 except for recipients who are diabetic or have poor circulation;

117.4 (3) bathing, including assistance with basic personal hygiene and skin care;

117.5 (4) eating, including assistance with hand washing and application of orthotics required
117.6 for eating, transfers, and feeding;

117.7 (5) transfers, including assistance with transferring the recipient from one seating or
117.8 reclining area to another;

117.9 (6) mobility, including assistance with ambulation, including use of a wheelchair.
117.10 Mobility does not include providing transportation for a recipient;

117.11 (7) positioning, including assistance with positioning or turning a recipient for necessary
117.12 care and comfort; and

117.13 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
117.14 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
117.15 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
117.16 clothing.

117.17 (c) Health-related procedures and tasks include the following covered services:

117.18 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
117.19 functioning;

117.20 (2) assistance with self-administered medication as defined by this section, including
117.21 reminders to take medication, bringing medication to the recipient, and assistance with
117.22 opening medication under the direction of the recipient or responsible party, including
117.23 medications given through a nebulizer;

117.24 (3) interventions for seizure disorders, including monitoring and observation; and

117.25 (4) other activities considered within the scope of the personal care service and meeting
117.26 the definition of health-related procedures and tasks under this section.

117.27 (d) A personal care assistant may provide health-related procedures and tasks associated
117.28 with the complex health-related needs of a recipient if the procedures and tasks meet the
117.29 definition of health-related procedures and tasks under this section and the personal care
117.30 assistant is trained by a qualified professional and demonstrates competency to safely
117.31 complete the procedures and tasks. Delegation of health-related procedures and tasks and
117.32 all training must be documented in the personal care assistance care plan and the recipient's

118.1 and personal care assistant's files. A personal care assistant must not determine the medication
118.2 dose or time for medication.

118.3 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
118.4 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
118.5 support there must be:

118.6 (1) delegation and training by a registered nurse, advanced practice registered nurse,
118.7 certified or licensed respiratory therapist, or a physician;

118.8 (2) utilization of clean rather than sterile procedure;

118.9 (3) specialized training about the health-related procedures and tasks and equipment,
118.10 including ventilator operation and maintenance;

118.11 (4) individualized training regarding the needs of the recipient; and

118.12 (5) supervision by a qualified professional who is a registered nurse.

118.13 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
118.14 recipient for episodes where there is a need for redirection due to behaviors. Training of
118.15 the personal care assistant must occur based on the needs of the recipient, the personal care
118.16 assistance care plan, and any other support services provided.

118.17 (g) Instrumental activities of daily living under subdivision 1, paragraph (i).

118.18 Sec. 147. Minnesota Statutes 2018, section 256B.0659, subdivision 4, is amended to read:

118.19 Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An
118.20 assessment as defined in subdivision 3a must be completed for personal care assistance
118.21 services.

118.22 (b) The following limitations apply to the assessment:

118.23 (1) a person must be assessed as dependent in an activity of daily living based on the
118.24 person's daily need or need on the days during the week the activity is completed for:

118.25 (i) cuing and constant supervision to complete the task; or

118.26 (ii) hands-on assistance to complete the task; and

118.27 (2) a child may not be found to be dependent in an activity of daily living if because of
118.28 the child's age an adult would either perform the activity for the child or assist the child
118.29 with the activity. Assistance needed is the assistance appropriate for a typical child of the
118.30 same age.

119.1 (c) Assessment for complex health-related needs must meet the criteria in this paragraph.
119.2 A recipient qualifies as having complex health-related needs if the recipient has one or more
119.3 of the interventions that are ordered by a physician or advanced practice registered nurse,
119.4 specified in a personal care assistance care plan or community support plan developed under
119.5 section 256B.0911, and found in the following:

119.6 (1) tube feedings requiring:

119.7 (i) a gastrojejunostomy tube; or

119.8 (ii) continuous tube feeding lasting longer than 12 hours per day;

119.9 (2) wounds described as:

119.10 (i) stage III or stage IV;

119.11 (ii) multiple wounds;

119.12 (iii) requiring sterile or clean dressing changes or a wound vac; or

119.13 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
119.14 care;

119.15 (3) parenteral therapy described as:

119.16 (i) IV therapy more than two times per week lasting longer than four hours for each
119.17 treatment; or

119.18 (ii) total parenteral nutrition (TPN) daily;

119.19 (4) respiratory interventions, including:

119.20 (i) oxygen required more than eight hours per day;

119.21 (ii) respiratory vest more than one time per day;

119.22 (iii) bronchial drainage treatments more than two times per day;

119.23 (iv) sterile or clean suctioning more than six times per day;

119.24 (v) dependence on another to apply respiratory ventilation augmentation devices such
119.25 as BiPAP and CPAP; and

119.26 (vi) ventilator dependence under section 256B.0652;

119.27 (5) insertion and maintenance of catheter, including:

119.28 (i) sterile catheter changes more than one time per month;

120.1 (ii) clean intermittent catheterization, and including self-catheterization more than six
120.2 times per day; or

120.3 (iii) bladder irrigations;

120.4 (6) bowel program more than two times per week requiring more than 30 minutes to
120.5 perform each time;

120.6 (7) neurological intervention, including:

120.7 (i) seizures more than two times per week and requiring significant physical assistance
120.8 to maintain safety; or

120.9 (ii) swallowing disorders diagnosed by a physician or advanced practice registered nurse
120.10 and requiring specialized assistance from another on a daily basis; and

120.11 (8) other congenital or acquired diseases creating a need for significantly increased direct
120.12 hands-on assistance and interventions in six to eight activities of daily living.

120.13 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
120.14 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
120.15 assistance at least four times per week and shows one or more of the following behaviors:

120.16 (1) physical aggression towards self or others, or destruction of property that requires
120.17 the immediate response of another person;

120.18 (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
120.19 or

120.20 (3) increased need for assistance for recipients who are verbally aggressive or resistive
120.21 to care so that the time needed to perform activities of daily living is increased.

120.22 Sec. 148. Minnesota Statutes 2018, section 256B.0659, subdivision 8, is amended to read:

120.23 Subd. 8. **Communication with recipient's physician or advanced practice registered**
120.24 **nurse.** The personal care assistance program requires communication with the recipient's
120.25 physician or advanced practice registered nurse about a recipient's assessed needs for personal
120.26 care assistance services. The commissioner shall work with the state medical director to
120.27 develop options for communication with the recipient's physician or advanced practice
120.28 registered nurse.

121.1 Sec. 149. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to
121.2 read:

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

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

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

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

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

121.11 (3) enroll with the department as a personal care assistant after clearing a background
121.12 study. Except as provided in subdivision 11a, before a personal care assistant provides
121.13 services, the personal care assistance provider agency must initiate a background study on
121.14 the personal care assistant under chapter 245C, and the personal care assistance provider
121.15 agency must have received a notice from the commissioner that the personal care assistant
121.16 is:

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

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

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

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

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

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

121.29 (8) effective January 1, 2010, complete standardized training as determined by the
121.30 commissioner before completing enrollment. The training must be available in languages
121.31 other than English and to those who need accommodations due to disabilities. Personal care
121.32 assistant training must include successful completion of the following training components:

122.1 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
122.2 roles and responsibilities of personal care assistants including information about assistance
122.3 with lifting and transfers for recipients, emergency preparedness, orientation to positive
122.4 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
122.5 training components, the personal care assistant must demonstrate the competency to provide
122.6 assistance to recipients;

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

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

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

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

122.18 Sec. 150. Minnesota Statutes 2018, section 256B.0913, subdivision 8, is amended to read:

122.19 Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The
122.20 case manager shall implement the coordinated service and support plan for each alternative
122.21 care client and ensure that a client's service needs and eligibility are reassessed at least every
122.22 12 months. The coordinated service and support plan must meet the requirements in section
122.23 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's
122.24 attending physician or advanced practice registered nurse as necessary to allow the individual
122.25 to remain in a community setting. In developing the individual's care plan, the case manager
122.26 should include the use of volunteers from families and neighbors, religious organizations,
122.27 social clubs, and civic and service organizations to support the formal home care services.
122.28 The lead agency shall be held harmless for damages or injuries sustained through the use
122.29 of volunteers under this subdivision including workers' compensation liability. The case
122.30 manager shall provide documentation in each individual's plan and, if requested, to the
122.31 commissioner that the most cost-effective alternatives available have been offered to the
122.32 individual and that the individual was free to choose among available qualified providers,
122.33 both public and private, including qualified case management or service coordination
122.34 providers other than those employed by any county; however, the county or tribe maintains

123.1 responsibility for prior authorizing services in accordance with statutory and administrative
123.2 requirements. The case manager must give the individual a ten-day written notice of any
123.3 denial, termination, or reduction of alternative care services.

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

123.9 Sec. 151. Minnesota Statutes 2018, section 256B.73, subdivision 5, is amended to read:

123.10 Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider
123.11 shall receive a health services benefit package that includes health services which the
123.12 enrollees might reasonably require to be maintained in good health, including emergency
123.13 care, inpatient hospital and physician or advanced practice registered nurse care, outpatient
123.14 health services, and preventive health services.

123.15 (b) Services related to chemical dependency, mental illness, vision care, dental care,
123.16 and other benefits may be excluded or limited upon approval by the commissioners. The
123.17 coalition may petition the commissioner of commerce or health, whichever is appropriate,
123.18 for waivers that allow these benefits to be excluded or limited.

123.19 (c) The commissioners, the coalition, and demonstration providers shall work together
123.20 to design a package of benefits or packages of benefits that can be provided to enrollees for
123.21 an affordable monthly premium.

123.22 Sec. 152. Minnesota Statutes 2018, section 256J.08, subdivision 73a, is amended to read:

123.23 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a
123.24 "qualified professional" means a licensed physician, a physician assistant, ~~a nurse practitioner~~
123.25 an advanced practice registered nurse, or a licensed chiropractor.

123.26 (b) For developmental disability and intelligence testing, a "qualified professional"
123.27 means an individual qualified by training and experience to administer the tests necessary
123.28 to make determinations, such as tests of intellectual functioning, assessments of adaptive
123.29 behavior, adaptive skills, and developmental functioning. These professionals include
123.30 licensed psychologists, certified school psychologists, or certified psychometrists working
123.31 under the supervision of a licensed psychologist.

124.1 (c) For learning disabilities, a "qualified professional" means a licensed psychologist or
124.2 school psychologist with experience determining learning disabilities.

124.3 (d) For mental health, a "qualified professional" means a licensed physician or a qualified
124.4 mental health professional. A "qualified mental health professional" means:

124.5 (1) for children, in psychiatric nursing, a registered nurse or advanced practice registered
124.6 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
124.7 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
124.8 certification organization or who has a master's degree in nursing or one of the behavioral
124.9 sciences or related fields from an accredited college or university or its equivalent, with at
124.10 least 4,000 hours of post-master's supervised experience in the delivery of clinical services
124.11 in the treatment of mental illness;

124.12 (2) for adults, in psychiatric nursing, a registered nurse or advanced practice registered
124.13 nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical
124.14 specialist in adult psychiatric and mental health nursing by a national nurse certification
124.15 organization or who has a master's degree in nursing or one of the behavioral sciences or
124.16 related fields from an accredited college or university or its equivalent, with at least 4,000
124.17 hours of post-master's supervised experience in the delivery of clinical services in the
124.18 treatment of mental illness;

124.19 (3) in clinical social work, a person licensed as an independent clinical social worker
124.20 under chapter 148D, or a person with a master's degree in social work from an accredited
124.21 college or university, with at least 4,000 hours of post-master's supervised experience in
124.22 the delivery of clinical services in the treatment of mental illness;

124.23 (4) in psychology, an individual licensed by the Board of Psychology under sections
124.24 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis
124.25 and treatment of mental illness;

124.26 (5) in psychiatry, a physician licensed under chapter 147 and certified by the American
124.27 Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

124.28 (6) in marriage and family therapy, the mental health professional must be a marriage
124.29 and family therapist licensed under sections 148B.29 to 148B.39, with at least two years of
124.30 post-master's supervised experience in the delivery of clinical services in the treatment of
124.31 mental illness; and

124.32 (7) in licensed professional clinical counseling, the mental health professional shall be
124.33 a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours

125.1 of post-master's supervised experience in the delivery of clinical services in the treatment
125.2 of mental illness.

125.3 Sec. 153. Minnesota Statutes 2018, section 256R.44, is amended to read:

125.4 **256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL**
125.5 **NECESSITY.**

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

125.13 Sec. 154. Minnesota Statutes 2018, section 256R.54, subdivision 1, is amended to read:

125.14 Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The
125.15 commissioner shall adopt rules under the Administrative Procedure Act to set the amount
125.16 and method of payment for ancillary materials and services provided to recipients residing
125.17 in nursing facilities. Payment for materials and services may be made to either the vendor
125.18 of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a
125.19 nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

125.20 (b) Payment for the same or similar service to a recipient shall not be made to both the
125.21 nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double
125.22 payments through audits and adjustments to the nursing facility's annual cost report as
125.23 required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements
125.24 for ancillary materials and services are cost-effective and as would be incurred by a prudent
125.25 and cost-conscious buyer.

125.26 (c) Therapy services provided to a recipient must be medically necessary and appropriate
125.27 to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician
125.28 or advanced practice registered nurse cannot provide adequate medical necessity justification,
125.29 as determined by the commissioner, the commissioner may recover or disallow the payment
125.30 for the services and may require prior authorization for therapy services as a condition of
125.31 payment or may impose administrative sanctions to limit the vendor, nursing facility, or
125.32 ordering physician's or advanced practice registered nurse's participation in the medical
125.33 assistance program. If the provider number of a nursing facility is used to bill services

126.1 provided by a vendor of therapy services that is not related to the nursing facility by
126.2 ownership, control, affiliation, or employment status, no withholding of payment shall be
126.3 imposed against the nursing facility for services not medically necessary except for funds
126.4 due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose
126.5 of this subdivision, no monetary recovery may be imposed against the nursing facility for
126.6 funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for
126.7 services not medically necessary.

126.8 (d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy
126.9 includes physical therapy, occupational therapy, speech therapy, audiology, and mental
126.10 health services that are covered services according to Minnesota Rules, parts 9505.0170 to
126.11 9505.0475.

126.12 (e) For purposes of this subdivision, "ancillary services" includes transportation defined
126.13 as a covered service in section 256B.0625, subdivision 17.

126.14 Sec. 155. Minnesota Statutes 2018, section 256R.54, subdivision 2, is amended to read:

126.15 Subd. 2. **Certification that treatment is appropriate.** The physical therapist,
126.16 occupational therapist, speech therapist, mental health professional, or audiologist who
126.17 provides or supervises the provision of therapy services, other than an initial evaluation, to
126.18 a medical assistance recipient must certify in writing that the therapy's nature, scope, duration,
126.19 and intensity are appropriate to the medical condition of the recipient every 30 days. The
126.20 therapist's statement of certification must be maintained in the recipient's medical record
126.21 together with the specific orders by the physician or advanced practice registered nurse and
126.22 the treatment plan. If the recipient's medical record does not include these documents, the
126.23 commissioner may recover or disallow the payment for such services. If the therapist
126.24 determines that the therapy's nature, scope, duration, or intensity is not appropriate to the
126.25 medical condition of the recipient, the therapist must provide a statement to that effect in
126.26 writing to the nursing facility for inclusion in the recipient's medical record. The
126.27 commissioner shall make recommendations regarding the medical necessity of services
126.28 provided.

126.29 Sec. 156. Minnesota Statutes 2018, section 257.63, subdivision 3, is amended to read:

126.30 Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered
126.31 nurse concerning the medical circumstances of the pregnancy itself and the condition and
126.32 characteristics of the child upon birth is not privileged.

127.1 Sec. 157. Minnesota Statutes 2018, section 257B.01, subdivision 3, is amended to read:

127.2 Subd. 3. **Attending physician or advanced practice registered nurse.** "Attending
127.3 physician or advanced practice registered nurse" means a physician or advanced practice
127.4 registered nurse who has primary responsibility for the treatment and care of the designator.
127.5 If physicians or advanced practice registered nurses share responsibility, another physician
127.6 or advanced practice registered nurse is acting on the attending physician's or advanced
127.7 practice registered nurse's behalf, or no physician or advanced practice registered nurse has
127.8 primary responsibility, any physician or advanced practice registered nurse who is familiar
127.9 with the designator's medical condition may act as an attending physician or advanced
127.10 practice registered nurse under this chapter.

127.11 Sec. 158. Minnesota Statutes 2018, section 257B.01, subdivision 9, is amended to read:

127.12 Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written
127.13 finding made by an attending physician or advanced practice registered nurse which states
127.14 that the designator suffers from a physically incapacitating disease or injury. No identification
127.15 of the illness in question is required.

127.16 Sec. 159. Minnesota Statutes 2018, section 257B.01, subdivision 10, is amended to read:

127.17 Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written
127.18 finding made by an attending physician or advanced practice registered nurse which states
127.19 the nature, extent, and probable duration of the designator's mental or organic incapacity.

127.20 Sec. 160. Minnesota Statutes 2018, section 257B.06, subdivision 7, is amended to read:

127.21 Subd. 7. **Restored capacity.** If a licensed physician or advanced practice registered
127.22 nurse determines that the designator has regained capacity, the co-custodian's authority that
127.23 commenced on the occurrence of a triggering event becomes inactive. Failure of a
127.24 co-custodian to immediately return the child(ren) to the designator's care entitles the
127.25 designator to an emergency hearing within five days of a request for a hearing.