

CHAPTER 58--H.F.No. 3989

An act relating to health; adding physician assistants to certain statutes; modifying references to advanced practice registered nurses; amending Minnesota Statutes 2020, sections 13.83, subdivision 2; 62A.15, subdivision 4, by adding a subdivision; 62A.3091, subdivision 2; 62D.09, subdivision 1; 62E.06, subdivision 1; 62J.17, subdivision 4a; 62J.48; 62J.823, subdivision 3; 62Q.184, subdivision 1; 62Q.57, subdivision 1; 62Q.73, subdivision 7; 62Q.733, subdivision 3; 62Q.74, subdivision 1; 62S.02, subdivision 5; 62S.08, subdivision 3; 62S.20, subdivision 5b; 62S.21, subdivision 2; 62S.268, subdivision 1; 97B.055, subdivision 3; 97B.106, subdivision 1; 97B.1115; 125A.02, subdivision 1; 144.3345, subdivision 1; 144.3352; 144.34; 144.441, subdivisions 4, 5; 144.442, subdivision 1; 144.4803, subdivisions 1, 4, 10, by adding a subdivision; 144.4806; 144.4807, subdivisions 1, 2, 4, 7; 144.50, subdivision 2; 144.55, subdivisions 2, 6; 144.6501, subdivision 7; 144.651, subdivisions 7, 8, 9, 10, 12, 14, 31, 33; 144.652, subdivision 2; 144.69; 144.7402, subdivision 2; 144.7406, subdivision 2; 144.7407, subdivision 2; 144.7414, subdivision 2; 144.7415, subdivision 2; 144.9502, subdivision 4; 144.966, subdivisions 3, 6; 144A.135; 144A.161, subdivisions 5, 5a, 5e, 5g; 144A.471, subdivision 7; 144A.4791, subdivision 13; 144A.75, subdivisions 3, 6; 144A.752, subdivision 1; 144G.08, by adding a subdivision; 144G.70, subdivision 7; 145.853, subdivision 5; 145.892, subdivision 3; 145.94, subdivision 2; 145B.13; 145C.02; 145C.05, subdivision 2; 145C.06; 145C.07, subdivision 1; 145C.16; 147A.27, subdivision 1; 148.6438, subdivision 1; 151.01, subdivision 27; 151.19, subdivision 4; 151.21, subdivision 4a; 151.37, subdivision 12; 152.22, subdivision 4; 152.32, subdivision 3; 176.011, subdivision 12a; 245.50, subdivision 5; 245A.143, subdivisions 2, 7, 8; 245A.1435; 245C.02, subdivision 18; 245C.04, subdivision 1; 245D.02, subdivision 11; 245D.22, subdivision 7; 245D.25, subdivision 2; 245F.02, subdivision 13; 245F.09, subdivision 2; 245G.08, subdivisions 2, 3, 5; 245G.21, subdivisions 2, 3; 245H.11; 246.711, subdivision 2; 246.715, subdivision 2; 246.716, subdivision 2; 246.721; 246.722; 251.043, subdivision 1; 253B.02, subdivision 9; 253B.03, subdivisions 4, 6d; 253B.06, subdivision 2; 253B.23, subdivision 4; 254A.08, subdivision 2; 256.9685, subdivisions 1a, 1b, 1c; 256.975, subdivisions 7a, 7b, 11; 256B.055, subdivision 12; 256B.0575, subdivision 1; 256B.0595, subdivision 3; 256B.0622, subdivision 2b; 256B.0625, subdivisions 2, 12, 26, 60a; 256B.0659, subdivisions 2, 4, 8, 27; 256B.0913, subdivision 8; 256B.0949, subdivision 5; 256B.73, subdivision 5; 256R.44; 256R.54, subdivisions 1, 2; 257.63, subdivision 3; 257B.01, subdivisions 3, 9, 10; 257B.06, subdivision 7; 259.24, subdivision 2; 260C.007, subdivision 6; 383A.13, subdivisions 3, 6; 609.341, subdivision 17; Minnesota Statutes 2021 Supplement, sections 62J.23, subdivision 2; 144G.08, subdivision 9; 147.091, subdivision 1; 151.37, subdivision 2; 252A.02, subdivision 12; 252A.04, subdivision 2; 252A.20, subdivision 1; 256B.0625, subdivisions 17, 28a, 49; 256B.0659, subdivision 11; 256B.0947, subdivision 3a; 256B.0949, subdivisions 4, 5a; 256P.01, subdivision 6a; repealing Minnesota Statutes 2020, sections 147A.01, subdivision 23; 151.37, subdivision 2a.

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

Section 1. Minnesota Statutes 2020, section 13.83, subdivision 2, is amended to read:

Subd. 2. **Public data.** Unless specifically classified otherwise by state statute or federal law, the following data created or collected by a medical examiner or coroner on a deceased individual are public: name of the deceased; date of birth; date of death; address; sex; race; citizenship; height; weight; hair color; eye color; build; complexion; age, if known, or approximate age; identifying marks, scars and amputations;

a description of the decedent's clothing; marital status; location of death including name of hospital where applicable; name of spouse; whether or not the decedent ever served in the armed forces of the United States; occupation; business; father's name (also birth name, if different); mother's name (also birth name, if different); birthplace; birthplace of parents; cause of death; causes of cause of death; whether an autopsy was performed and if so, whether it was conclusive; date and place of injury, if applicable, including work place; how injury occurred; whether death was caused by accident, suicide, homicide, or was of undetermined cause; certification of attendance by physician ~~or~~, advanced practice registered nurse, or physician assistant; physician's ~~or~~, advanced practice registered nurse's, or physician assistant's name and address; certification by coroner or medical examiner; name and signature of coroner or medical examiner; type of disposition of body; burial place name and location, if applicable; date of burial, cremation or removal; funeral home name and address; and name of local register or funeral director.

Sec. 2. Minnesota Statutes 2020, section 62A.15, is amended by adding a subdivision to read:

Subd. 3c. **Physician assistant services.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a licensed physician, must include services provided by a physician assistant licensed under chapter 147A. This subdivision is intended to provide payment of benefits for treatment and services by a physician assistant and is not intended to add to the benefits provided for in these policies or contracts.

Sec. 3. Minnesota Statutes 2020, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, a licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed physician assistant, or a licensed acupuncture practitioner.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

Sec. 4. Minnesota Statutes 2020, section 62A.3091, subdivision 2, is amended to read:

Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and x-rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to chapter 148 or a physician assistant practicing pursuant to chapter 147A. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice nurse or between a physician and a physician assistant.

Sec. 5. Minnesota Statutes 2020, section 62D.09, subdivision 1, is amended to read:

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

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

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

- (1) health care services not provided;
- (2) health care services requiring co-payments or deductibles paid by enrollees;
- (3) the fact that access to health care services does not guarantee access to a particular provider type; and
- (4) health care services that are or may be provided only by referral of a physician ~~or~~, advanced practice registered nurse, or physician assistant.

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

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

Sec. 6. Minnesota Statutes 2020, section 62E.06, subdivision 1, is amended to read:

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

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

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

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

- (1) hospital services;

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

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

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

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

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

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

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

(11) diagnostic x-rays and laboratory tests;

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

(13) services of a physical therapist;

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

(15) services of an occupational therapist.

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2020, section 62J.17, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2021 Supplement, section 62J.23, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

(1) activities permitted under paragraph (b);

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

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

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

Sec. 9. Minnesota Statutes 2020, section 62J.48, is amended to read:

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144E.10 are eligible for reimbursement under health plan companies. The commissioner shall require health plan companies to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician ~~or~~ nurse, or physician assistant, and, if the person is an enrollee in a health plan company, if approved by a designated representative of a health plan company who is immediately available on a 24-hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

Sec. 10. Minnesota Statutes 2020, section 62J.823, subdivision 3, is amended to read:

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

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

(2) at least one of the following:

(i) the specific diagnostic-related group code;

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

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

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

Sec. 11. Minnesota Statutes 2020, section 62Q.184, subdivision 1, is amended to read:

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2020, section 62Q.57, subdivision 1, is amended to read:

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

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

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

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

Sec. 13. Minnesota Statutes 2020, section 62Q.73, subdivision 7, is amended to read:

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

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

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

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including:

(1) medical records;

(2) the recommendation of the attending physician, advanced practice registered nurse, physician assistant, or health care professional's recommendation, professional;

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

(6) medical or scientific evidence or evidence-based standards.

Sec. 14. Minnesota Statutes 2020, section 62Q.733, subdivision 3, is amended to read:

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

Sec. 15. Minnesota Statutes 2020, section 62Q.74, subdivision 1, is amended to read:

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

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

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

Sec. 16. Minnesota Statutes 2020, section 62S.02, subdivision 5, is amended to read:

Subd. 5. **Activities of daily living.** A qualified long-term care insurance policy shall take into account at least five of the activities of daily living in making the determination of whether an individual is chronically ill. Assessments of activities of daily living and cognitive impairment must be performed by a licensed or certified professional, such as a physician, physician assistant, nurse, or social worker.

Sec. 17. Minnesota Statutes 2020, section 62S.08, subdivision 3, is amended to read:

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

COMPANY NAME

ADDRESS - CITY AND STATE

TELEPHONE NUMBER

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

Policy Number or Group Master Policy and Certificate Number

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) BENEFITS PROVIDED BY THIS POLICY.

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

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

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

(d) (Eligibility for payment of benefits.)

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

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

(10) LIMITATIONS AND EXCLUSIONS:

Describe:

- (a) preexisting conditions;
- (b) noneligible facilities/provider;
- (c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) exclusions/exceptions; and
- (e) limitations.

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

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

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

- (a) that the benefit level will not increase over time;
- (b) any automatic benefit adjustment provisions;
- (c) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) if there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and
- (e) whether there will be any additional premium charge imposed and how that is to be calculated.

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

(13) PREMIUM.

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

(14) ADDITIONAL FEATURES.

- (a) Indicate if medical underwriting is used.
- (b) Describe other important features.

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

Sec. 18. Minnesota Statutes 2020, section 62S.20, subdivision 5b, is amended to read:

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

Sec. 19. Minnesota Statutes 2020, section 62S.21, subdivision 2, is amended to read:

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

Sec. 20. Minnesota Statutes 2020, section 62S.268, subdivision 1, is amended to read:

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2020, section 97B.055, subdivision 3, is amended to read:

Subd. 3. **Hunting from vehicle by disabled hunters.** (a) The commissioner may issue a special permit, without a fee, to discharge a firearm or bow and arrow from a stationary motor vehicle to a person who obtains the required licenses and who has a permanent physical disability that is more substantial than discomfort from walking. The permit recipient must be:

(1) unable to step from a vehicle without aid of a wheelchair, crutches, braces, or other mechanical support or prosthetic device; or

(2) unable to walk any distance because of a permanent lung, heart, or other internal disease that requires the person to use supplemental oxygen to assist breathing.

(b) The permanent physical disability must be established by medical evidence verified in writing by a licensed physician, chiropractor, ~~or certified nurse practitioner~~ advanced practice registered nurse, or ~~certified licensed physician assistant acting under the direction of a licensed physician~~. The commissioner may request additional information from the physician ~~or~~ chiropractor, advanced practice registered nurse, or physician assistant if needed to verify the applicant's eligibility for the permit. Notwithstanding section 97A.418, the commissioner may, in consultation with appropriate advocacy groups, establish reasonable minimum standards for permits to be issued under this section. In addition to providing the medical evidence of a permanent disability, the applicant must possess a valid disability parking certificate authorized by section 169.345 or license plates issued under section 168.021.

(c) A person issued a special permit under this subdivision and hunting deer may take a deer of either sex, except in those antlerless permit areas and seasons where no antlerless permits are offered. This subdivision does not authorize another member of a party to take an antlerless deer under section 97B.301, subdivision 3.

(d) A permit issued under this subdivision is valid for five years.

(e) The commissioner may deny, modify, suspend, or revoke a permit issued under this section for cause, including a violation of the game and fish laws or rules.

(f) A person who knowingly makes a false application or assists another in making a false application for a permit under this section is guilty of a misdemeanor. A licensed physician, ~~certified nurse practitioner~~ licensed advanced practice registered nurse, ~~certified~~ licensed physician assistant, or licensed chiropractor who fraudulently certifies to the commissioner that a person is permanently disabled as described in this section is guilty of a misdemeanor.

(g) Notwithstanding paragraph (d), the commissioner may issue a permit valid for the entire life of the applicant if the commissioner determines that there is no chance that an applicant will become ineligible for a permit under this section and the applicant requests a lifetime permit.

Sec. 22. Minnesota Statutes 2020, section 97B.106, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) The commissioner may issue a special permit, without a fee, to take big game, small game, or rough fish with a crossbow to a person that is unable to hunt or take rough fish by

archery because of a permanent or temporary physical disability. A crossbow permit issued under this section also allows the permittee to use a bow with a mechanical device that draws, releases, or holds the bow at full draw as provided in section 97B.035, subdivision 1, paragraph (a).

(b) To qualify for a crossbow permit under this section, a temporary disability must render the person unable to hunt or fish by archery for a minimum of two years after application for the permit is made. The permanent or temporary disability must be established by medical evidence, and the inability to hunt or fish by archery for the required period of time must be verified in writing by (1) a licensed physician ~~or a certified nurse practitioner~~ licensed advanced practice registered nurse, or ~~certified~~ licensed physician assistant ~~acting under the direction of a licensed physician~~; or (2) a licensed chiropractor. A person who has received a special permit under this section because of a permanent disability is eligible for subsequent special permits without providing medical evidence and verification of the disability.

(c) The person must obtain the appropriate license.

Sec. 23. Minnesota Statutes 2020, section 97B.1115, is amended to read:

97B.1115 USING MECHANICAL OR ELECTRONIC ASSISTANCE TO HOLD AND DISCHARGE FIREARMS OR BOWS; PERSON WITH PHYSICAL DISABILITY.

(a) Notwithstanding sections 97B.035, subdivision 1, 97B.321, and 97B.701, subdivision 2, the commissioner may issue a special permit to take big game and small game, without a fee, to a person with a physical disability who has a verified statement of the disability from a licensed physician ~~or a certified nurse practitioner~~ licensed advanced practice registered nurse, or ~~certified~~ licensed physician assistant ~~acting under the direction of a licensed physician~~ to use a swivel or otherwise mounted firearm or bow or any electronic or mechanical device to discharge a firearm or bow as long as the participant is physically present at the site.

(b) A person using mechanical or electronic assistance under this section may be assisted by another person. The person assisting may take a wounded animal shot by the person using mechanical or electronic assistance under this section if the person with the disability is physically incapable of doing so. The person assisting must be licensed to take the animal.

Sec. 24. Minnesota Statutes 2020, section 125A.02, subdivision 1, is amended to read:

Subdivision 1. **Child with a disability.** "Child with a disability" means a child identified under federal and state special education law as deaf or hard-of-hearing, blind or visually impaired, deafblind, or having a speech or language impairment, a physical impairment, other health disability, developmental cognitive disability, an emotional or behavioral disorder, specific learning disability, autism spectrum disorder, traumatic brain injury, or severe multiple impairments, and who needs special education and related services, as determined by the rules of the commissioner. A licensed physician, an advanced practice nurse, a physician assistant, or a licensed psychologist is qualified to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder for purposes of identifying a child with a disability.

Sec. 25. Minnesota Statutes 2020, section 144.3345, subdivision 1, is amended to read:

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

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

have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2020, section 144.3352, is amended to read:

144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT IMMUNIZATION.

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

Sec. 27. Minnesota Statutes 2020, section 144.34, is amended to read:

144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.

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

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

Sec. 28. Minnesota Statutes 2020, section 144.441, subdivision 4, is amended to read:

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

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

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

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

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

Sec. 29. Minnesota Statutes 2020, section 144.441, subdivision 5, is amended to read:

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

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

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

Sec. 30. Minnesota Statutes 2020, section 144.442, subdivision 1, is amended to read:

Subdivision 1. **Administration; notification.** In the event that the commissioner designates a school or school district under section 144.441, subdivision 2, the school or school district or community health

board may administer Mantoux screening tests to some or all persons enrolled in or employed by the designated school or school district. Any Mantoux screening provided under this section shall be under the direction of a licensed physician ~~or~~, advanced practice registered nurse, or physician assistant.

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

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

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

(3) the manner by which tuberculosis is transmitted;

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

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

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

(7) that screening has been scheduled; and

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

Sec. 31. Minnesota Statutes 2020, section 144.4803, subdivision 1, is amended to read:

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

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

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

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

Sec. 32. Minnesota Statutes 2020, section 144.4803, subdivision 4, is amended to read:

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

Sec. 33. Minnesota Statutes 2020, section 144.4803, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2020, section 144.4803, is amended by adding a subdivision to read:

Subd. 17a. **Physician assistant.** "Physician assistant" means a person who is licensed by the Board of Medical Practice under chapter 147A to practice as a physician assistant.

Sec. 35. Minnesota Statutes 2020, section 144.4806, is amended to read:

144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.

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

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2020, section 144.4807, subdivision 1, is amended to read:

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

Sec. 37. Minnesota Statutes 2020, section 144.4807, subdivision 2, is amended to read:

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

Sec. 38. Minnesota Statutes 2020, section 144.4807, subdivision 4, is amended to read:

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

Sec. 39. Minnesota Statutes 2020, section 144.4807, subdivision 7, is amended to read:

Subd. 7. **Court order extending 72-hour hold.** The court may extend the hold under subdivision 5 by up to six days, excluding Saturdays, Sundays, and legal holidays, if the court finds that there is probable cause to believe that the carrier is an endangerment to the public health. The court may find probable cause to detain, examine, and isolate the carrier based upon a written statement by facsimile or upon an oral statement by telephone from the carrier's attending physician ~~or~~, nurse, or physician assistant; a public health physician ~~or~~, nurse, or physician assistant; other licensed health professional~~s~~; or disease prevention officer, stating the grounds and facts that demonstrate that the carrier is an endangerment to the public health, provided that an affidavit from such witness is filed with the court within 72 hours, excluding Saturdays, Sundays, and legal holidays. The order may be issued orally by telephone, or by facsimile, provided that a written order is issued within 72 hours, excluding Saturdays, Sundays, and legal holidays. The oral and written order shall contain a notice of the carrier's rights contained in section 144.4805, subdivision 3, clause (6). A carrier may not be released prior to the hold extended under this subdivision without the express consent of the commissioner.

Sec. 40. Minnesota Statutes 2020, section 144.50, subdivision 2, is amended to read:

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

Sec. 41. Minnesota Statutes 2020, section 144.55, subdivision 2, is amended to read:

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

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

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

Sec. 42. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

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

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

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

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

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

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

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

Sec. 43. Minnesota Statutes 2020, section 144.6501, subdivision 7, is amended to read:

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

Sec. 44. Minnesota Statutes 2020, section 144.651, subdivision 7, is amended to read:

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

Sec. 45. Minnesota Statutes 2020, section 144.651, subdivision 8, is amended to read:

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

Sec. 46. Minnesota Statutes 2020, section 144.651, subdivision 9, is amended to read:

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

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

Sec. 47. Minnesota Statutes 2020, section 144.651, subdivision 10, is amended to read:

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

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

- (1) examining the personal effects of the patient or resident;
- (2) examining the medical records of the patient or resident in the possession of the facility;

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

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

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

Sec. 48. Minnesota Statutes 2020, section 144.651, subdivision 12, is amended to read:

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

Sec. 49. Minnesota Statutes 2020, section 144.651, subdivision 14, is amended to read:

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

Sec. 50. Minnesota Statutes 2020, section 144.651, subdivision 31, is amended to read:

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

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

Sec. 51. Minnesota Statutes 2020, section 144.651, subdivision 33, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 52. Minnesota Statutes 2020, section 144.652, subdivision 2, is amended to read:

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

Sec. 53. Minnesota Statutes 2020, section 144.69, is amended to read:

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

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

Sec. 54. Minnesota Statutes 2020, section 144.7402, subdivision 2, is amended to read:

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

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

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

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

Sec. 55. Minnesota Statutes 2020, section 144.7406, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** If the source individual has provided a blood sample with consent but does not consent to blood-borne pathogen testing, the facility shall test for blood-borne pathogens

if the emergency medical services person or emergency medical services agency requests the test, provided all of the following criteria are met:

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

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

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

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

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

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

Sec. 56. Minnesota Statutes 2020, section 144.7407, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 57. Minnesota Statutes 2020, section 144.7414, subdivision 2, is amended to read:

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

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

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

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

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

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

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

Sec. 58. Minnesota Statutes 2020, section 144.7415, subdivision 2, is amended to read:

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

Sec. 59. Minnesota Statutes 2020, section 144.9502, subdivision 4, is amended to read:

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

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

Sec. 60. Minnesota Statutes 2020, section 144.966, subdivision 3, is amended to read:

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

- (1) in advance of any hearing screening testing, provide to the newborn's or infant's parents or parent information concerning the nature of the screening procedure, applicable costs of the screening procedure, the potential risks and effects of hearing loss, and the benefits of early detection and intervention;
- (2) comply with parental election as described under section 144.125, subdivision 4;
- (3) develop policies and procedures for screening and rescreening based on Department of Health recommendations;
- (4) provide appropriate training and monitoring of individuals responsible for performing hearing screening tests as recommended by the Department of Health;

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

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

(7) inform the newborn's or infant's parents or parent~~s~~; primary care physician ~~or~~ advanced practice registered nurse, physician assistant; and the Department of Health according to recommendations of the Department of Health of the results of the hearing screening test or rescreening if conducted, or if the newborn or infant was not successfully tested. The hospital that discharges the newborn or infant to home is responsible for the screening; and

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

Sec. 61. Minnesota Statutes 2020, section 144.966, subdivision 6, is amended to read:

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

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

Sec. 62. Minnesota Statutes 2020, section 144A.135, is amended to read:

144A.135 TRANSFER AND DISCHARGE APPEALS.

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

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

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

(d) A resident who timely appeals a notice of discharge or transfer, and who resides in a certified nursing home or boarding care home, may not be discharged or transferred by the nursing home or boarding care home until resolution of the appeal. The commissioner can order the facility to readmit the resident if the discharge or transfer was in violation of state or federal law. If the resident is required to be hospitalized for medical necessity before resolution of the appeal, the facility shall readmit the resident unless the resident's attending physician ~~or~~ advanced practice registered nurse, physician assistant documents, in writing, why the resident's specific health care needs cannot be met in the facility.

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

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

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

Sec. 63. Minnesota Statutes 2020, section 144A.161, subdivision 5, is amended to read:

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

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

- (1) resident name;
- (2) date of birth;
- (3) Social Security number;
- (4) payment source and medical assistance identification number, if applicable;
- (5) county of financial responsibility if the resident is enrolled in a Minnesota health care program;
- (6) date of admission to the facility;
- (7) all current diagnoses;
- (8) the name of and contact information for the resident's physician ~~or~~, advanced practice registered nurse, or physician assistant;
- (9) the name and contact information for the resident's responsible party;
- (10) the name of and contact information for any case manager, managed care coordinator, or other care coordinator, if known;
- (11) information on the resident's status related to commitment and probation; and
- (12) the name of the managed care organization in which the resident is enrolled, if known.

Sec. 64. Minnesota Statutes 2020, section 144A.161, subdivision 5a, is amended to read:

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

- (1) the date of the proposed closure, reduction, or change in operations;
- (2) the contact information of the individual or individuals in the facility responsible for providing assistance and information;
- (3) notification of upcoming meetings for residents, responsible parties, and resident and family councils to discuss the plan for relocation of residents;
- (4) the contact information of the county social services agency contact person; and
- (5) the contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

Sec. 65. Minnesota Statutes 2020, section 144A.161, subdivision 5e, is amended to read:

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

Sec. 66. Minnesota Statutes 2020, section 144A.161, subdivision 5g, is amended to read:

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

- (1) be provided prior to the actual relocation; and
 - (2) identify the effective date of the anticipated relocation and the destination to which the resident is being relocated.
- (b) The licensee shall provide the receiving facility or other health, housing, or care entity with complete and accurate resident records including contact information for family members, responsible parties, social service or other caseworkers, and managed care coordinators. These records must also include all information necessary to provide appropriate medical care and social services. This includes, but is not limited to, information on preadmission screening, Level I and Level II screening, minimum data set (MDS), all other

assessments, current resident diagnoses, social, behavioral, and medication information, required forms, and discharge summaries.

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

Sec. 67. Minnesota Statutes 2020, section 144A.471, subdivision 7, is amended to read:

Subd. 7. **Comprehensive home care license provider.** Home care services that may be provided with a comprehensive home care license include any of the basic home care services listed in subdivision 6, and one or more of the following:

(1) services of an advanced practice nurse, physician assistant, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;

(3) medication management services;

(4) hands-on assistance with transfers and mobility;

(5) treatment and therapies;

(6) assisting clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or

(7) providing other complex or specialty health care services.

Sec. 68. Minnesota Statutes 2020, section 144A.4791, subdivision 13, is amended to read:

Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform the supervisor or other agent of the home care provider of the client's request.

(b) Upon being informed of a request for termination of treatment, the home care provider shall promptly:

(1) inform the client that the request will be made known to the physician ~~or~~ advanced practice registered nurse, or physician assistant who ordered the client's treatment;

(2) inform the physician ~~or~~ advanced practice registered nurse, or physician assistant of the client's request; and

(3) work with the client and the client's physician ~~or~~ advanced practice registered nurse, or physician assistant to comply with the provisions of the Health Care Directive Act in chapter 145C.

(c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters.

Sec. 69. Minnesota Statutes 2020, section 144A.75, subdivision 3, is amended to read:

Subd. 3. **Core services.** "Core services" means physician services, registered nursing services, advanced practice registered nurse services, physician assistant services, medical social services, and counseling services. A hospice must ensure that at least two core services are regularly provided directly by hospice employees. A hospice provider may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during peak patient loads or under extraordinary circumstances.

Sec. 70. Minnesota Statutes 2020, section 144A.75, subdivision 6, is amended to read:

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

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

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

Sec. 71. Minnesota Statutes 2020, section 144A.752, subdivision 1, is amended to read:

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

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

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

(3) standards of training of hospice provider personnel;

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

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

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

Sec. 72. Minnesota Statutes 2021 Supplement, section 144G.08, subdivision 9, is amended to read:

Subd. 9. **Assisted living services.** "Assisted living services" includes one or more of the following:

- (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;
- (2) providing standby assistance;
- (3) providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication;
- (4) providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises;
- (5) preparing specialized diets ordered by a licensed health professional;
- (6) services of an advanced practice registered nurse, physician assistant, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;
- (7) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;
- (8) medication management services;
- (9) hands-on assistance with transfers and mobility;
- (10) treatment and therapies;
- (11) assisting residents with eating when the residents have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed;
- (12) providing other complex or specialty health care services; and
- (13) supportive services in addition to the provision of at least one of the services listed in clauses (1) to (12).

Sec. 73. Minnesota Statutes 2020, section 144G.08, is amended by adding a subdivision to read:

Subd. 52a. **Physician assistant.** "Physician assistant" means a person who is licensed under chapter 147A.

Sec. 74. Minnesota Statutes 2020, section 144G.70, subdivision 7, is amended to read:

Subd. 7. **Request for discontinuation of life-sustaining treatment.** (a) If a resident, family member, or other caregiver of the resident requests that an employee or other agent of the facility discontinue a life-sustaining treatment, the employee or agent receiving the request:

- (1) shall take no action to discontinue the treatment; and
 - (2) shall promptly inform the supervisor or other agent of the facility of the resident's request.
- (b) Upon being informed of a request for discontinuance of treatment, the facility shall promptly:

(1) inform the resident that the request will be made known to the physician ~~or~~, advanced practice registered nurse, or physician assistant who ordered the resident's treatment;

(2) inform the physician ~~or~~, advanced practice registered nurse, or physician assistant of the resident's request; and

(3) work with the resident and the resident's physician ~~or~~, advanced practice registered nurse, or physician assistant to comply with chapter 145C.

(c) This section does not require the facility to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of residents to control their treatments, refuse services, or terminate their relationships with the facility.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by residents under those chapters.

Sec. 75. Minnesota Statutes 2020, section 145.853, subdivision 5, is amended to read:

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

Sec. 76. Minnesota Statutes 2020, section 145.892, subdivision 3, is amended to read:

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

Sec. 77. Minnesota Statutes 2020, section 145.94, subdivision 2, is amended to read:

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

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

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

Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage according to established standards to prevent unauthorized use or disclosure. If the nonpublic data is required for the diagnosis, treatment, or prevention of illness or injury, a personal physician ~~or~~, advanced practice registered nurse, or physician assistant may be provided with this information if the physician ~~or~~, advanced practice

registered nurse, or physician assistant agrees to preserve the confidentiality of the information, except for patient health records subject to sections 144.291 to 144.298. After the disclosure of any hazardous substance information relating to a particular workplace, the commissioner shall advise the employer of the information disclosed, the date of the disclosure, and the person who received the information.

Sec. 78. Minnesota Statutes 2020, section 145B.13, is amended to read:

145B.13 REASONABLE MEDICAL PRACTICE REQUIRED.

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

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

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

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

Sec. 79. Minnesota Statutes 2020, section 145C.02, is amended to read:

145C.02 HEALTH CARE DIRECTIVE.

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

Sec. 80. Minnesota Statutes 2020, section 145C.05, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 81. Minnesota Statutes 2020, section 145C.06, is amended to read:

145C.06 WHEN EFFECTIVE.

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

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

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

A health care directive is not effective for a health care decision when the principal, in the determination of the attending physician ~~or~~₂ advanced practice registered nurse, or physician assistant of the principal, recovers decision-making capacity; or if other conditions for effectiveness otherwise specified by the principal have been met.

Sec. 82. Minnesota Statutes 2020, section 145C.07, subdivision 1, is amended to read:

Subdivision 1. **Authority.** The health care agent has authority to make any particular health care decision only if the principal lacks decision-making capacity, in the determination of the attending physician ~~or~~₂ advanced practice registered nurse, or physician assistant, to make or communicate that health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met. The physician, advanced practice registered nurse, physician assistant, or other health care provider shall continue to obtain the principal's informed consent to all health care decisions for which the principal has decision-making capacity, unless other conditions for effectiveness otherwise specified by the principal have been met. An alternate health care agent has authority to act if the primary health care agent is not reasonably available to act.

Sec. 83. Minnesota Statutes 2020, section 145C.16, is amended to read:

145C.16 SUGGESTED FORM.

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

HEALTH CARE DIRECTIVE

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

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

AND/OR

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

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS

FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

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

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

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

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

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

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

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

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

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

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

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

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

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

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

(B) Choose my health care providers.

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

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

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

.....
.....

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

- (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.
- (2) To decide what will happen with my body when I die (burial, cremation).

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

.....
.....
.....

PART II: HEALTH CARE INSTRUCTIONS

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

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

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

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

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

My goals for my health care:.....

.....
.....

My fears about my health care:.....

.....
.....

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

.....
.....

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

.....

.....

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

.....

.....

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

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

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

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

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

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

.....

.....

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

.....

.....

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

.....

.....

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

.....

.....

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

.....

.....

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

Who I would like to be my doctor or, advanced practice registered nurse, or physician assistant:.....

.....
.....

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

.....
.....

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

.....
.....

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

.....
.....

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

.....
.....

Any other things:.....

.....
.....

PART III: MAKING THE DOCUMENT LEGAL

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

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

.....

My Signature

Date signed:

Date of birth:

Address:

.....

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

.....

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

.....

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

Option 1: Notary Public

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

.....

(Signature of Notary)

(Notary Stamp)

Option 2: Two Witnesses

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

Witness One:

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

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

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

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

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

.....

(Signature of Witness One)

Address:
.....

Witness Two:

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

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

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

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

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

.....

(Signature of Witness Two)

Address:
.....

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

Sec. 84. Minnesota Statutes 2021 Supplement, section 147.091, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may refuse to grant a license, may refuse to grant registration to perform interstate telehealth services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathic medicine. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.

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

(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 604.201, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in any unethical or improper conduct, including but not limited to:

(1) conduct likely to deceive or defraud the public;

(2) conduct likely to harm the public;

(3) conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient;

(4) medical practice that is professionally incompetent; and

(5) conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to provide proper supervision, including but not limited to supervision of a:

~~(1) physician assistant;~~

~~(2)~~ (1) licensed or unlicensed health care provider; and

~~(3)~~ (2) physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication by a court of competent jurisdiction, within or outside this state, as:

(1) mentally incompetent;

(2) mentally ill;

(3) developmentally disabled;

(4) a chemically dependent person;

(5) a person dangerous to the public;

(6) a sexually dangerous person; or

(7) a person who has a sexual psychopathic personality.

Such adjudication shall automatically suspend a license for the duration of the adjudication unless the board orders otherwise.

(k) Conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proof of actual injury need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients by reason of the following, including but not limited to:

- (1) illness;
- (2) intoxication;
- (3) use of drugs, narcotics, chemicals, or any other type of substance;
- (4) mental condition;
- (5) physical condition;
- (6) diminished cognitive ability;
- (7) loss of motor skills; or
- (8) deterioration through the aging process.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathic medicine to identify the school of healing in the professional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathic medicine, or D.O.

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the referring physician has a "financial or economic interest," as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician's financial or economic interest in accordance with section 144.6521; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.

The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(r) Becoming addicted or habituated to a drug or intoxicant.

(s) Inappropriate prescribing of or failure to properly prescribe a drug or device, including prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency.

(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of the board as required by section 147.131.

(v) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

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

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

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

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

(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.

(y) Failure to repay a state or federally secured student loan in accordance with the provisions of the loan.

(z) Providing interstate telehealth services other than according to section 147.032.

Sec. 85. Minnesota Statutes 2020, section 147A.27, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The Physician Assistant Advisory Council is created and is composed of seven persons appointed by the board. The seven persons must include:

(1) two public members, as defined in section 214.02;

(2) three physician assistants licensed under this chapter who meet the criteria for a new applicant under section 147A.02; and

(3) two licensed physicians with experience ~~supervising~~ practicing with physician assistants.

Sec. 86. Minnesota Statutes 2020, section 148.6438, subdivision 1, is amended to read:

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

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

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

Sec. 87. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

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

- (1) interpretation and evaluation of prescription drug orders;
- (2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);
- (3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;
- (4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; intramuscular and subcutaneous administration used for the treatment of alcohol or opioid dependence; drug regimen reviews; and drug or drug-related research;
- (5) drug administration, through intramuscular and subcutaneous administration used to treat mental illnesses as permitted under the following conditions:
 - (i) upon the order of a prescriber and the prescriber is notified after administration is complete; or
 - (ii) pursuant to a protocol or collaborative practice agreement as defined by section 151.01, subdivisions 27b and 27c, and participation in the initiation, management, modification, administration, and discontinuation of drug therapy is according to the protocol or collaborative practice agreement between the pharmacist and a dentist, optometrist, physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy or medication administration made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;
- (6) participation in administration of influenza vaccines and vaccines approved by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a

physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

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

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

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

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

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

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

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

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

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

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

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

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

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

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

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

(i) a written protocol as allowed under clause (7); or

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

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

Sec. 88. Minnesota Statutes 2020, section 151.19, subdivision 4, is amended to read:

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

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

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

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

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

Sec. 89. Minnesota Statutes 2020, section 151.21, subdivision 4a, is amended to read:

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

Sec. 90. Minnesota Statutes 2021 Supplement, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, ~~a physician assistant~~, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; ~~physician assistant~~; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. ~~This paragraph applies to a physician assistant only if the physician assistant meets the requirements of sections 147A.02 and 147A.09.~~

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

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a

licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

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

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

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

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

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

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if:

(1) an in-person examination has been completed in any of the following circumstances:

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

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

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

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

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

(2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication-assisted therapy for a substance use disorder, and the prescribing practitioner has completed an examination of the patient via telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

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

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

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

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

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

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

Sec. 91. Minnesota Statutes 2020, section 151.37, subdivision 12, is amended to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant ~~authorized to prescribe drugs pursuant to section 147A.18~~ may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

- (1) an emergency medical responder registered pursuant to section 144E.27;
- (2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);
- (3) correctional employees of a state or local political subdivision;
- (4) staff of community-based health disease prevention or social service programs;
- (5) a volunteer firefighter; and

(6) a licensed school nurse or certified public health nurse employed by, or under contract with, a school board under section 121A.21.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

Sec. 92. Minnesota Statutes 2020, section 152.22, subdivision 4, is amended to read:

Subd. 4. **Health care practitioner.** "Health care practitioner" means a Minnesota licensed doctor of medicine, a Minnesota licensed physician assistant ~~acting within the scope of authorized practice~~, or a Minnesota licensed advanced practice registered nurse who has the primary responsibility for the care and treatment of the qualifying medical condition of a person diagnosed with a qualifying medical condition.

Sec. 93. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

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

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

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

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

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

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

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

Sec. 94. Minnesota Statutes 2020, section 176.011, subdivision 12a, is amended to read:

Subd. 12a. **Health care provider.** "Health care provider" means a physician, podiatrist, chiropractor, dentist, optometrist, osteopathic physician, psychologist, psychiatric social worker, physician assistant, or any other person who furnishes a medical or health service to an employee under this chapter but does not include a qualified rehabilitation consultant or approved vendor.

Sec. 95. Minnesota Statutes 2020, section 245.50, subdivision 5, is amended to read:

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals

covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness, chemical dependency, or detoxification. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, a licensed psychologist who has a doctoral degree in psychology, or an ~~advance~~ advanced practice registered nurse certified in mental health, who is licensed in the bordering state, may act as ~~an~~ a court examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7. ~~Such~~ An examiner under section 253B.02, subdivision 7, may initiate an emergency hold under section ~~253B.05~~ 253B.051 on a Minnesota resident who is in a hospital that is under contract with a Minnesota governmental entity under this section provided the resident, in the opinion of the examiner, meets the criteria in section ~~253B.05~~ 253B.051.

(g) This section shall apply to detoxification services that are unrelated to treatment whether the services are provided on a voluntary or involuntary basis.

Sec. 96. Minnesota Statutes 2020, section 245A.143, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the following meanings unless otherwise provided for by text.

(b) "Caregiver" means a spouse, adult child, parent, relative, friend, or others who normally provide unpaid support or care to the individual needing assistance. For the purpose of this section, the caregiver may or may not have legal or financial responsibility for the participant.

(c) "Participant" means a functionally impaired adult receiving family adult day services.

(d) "Consultation by a health care professional" means the review and oversight of the participant's health-related services by a registered nurse, physician, physician assistant, or mental health professional.

Sec. 97. Minnesota Statutes 2020, section 245A.143, subdivision 7, is amended to read:

Subd. 7. **Health services.** (a) The license holder shall provide health services as specified in the service delivery plan under the direction of the designated caregiver or county or private case manager. Health services must include:

(1) monitoring the participant's level of function and health while participating; taking appropriate action for a change in condition including immediately reporting changes to the participant's caregiver, physician, physician assistant, mental health professional, or registered nurse; and seeking consultation;

(2) offering information to participants and caregivers on good health and safety practices; and

(3) maintaining a listing of health resources available for referrals as needed by participants and caregivers.

(b) Unless the person is a licensed health care practitioner qualified to administer medications, the person responsible for medication administration or assistance shall provide a certificate verifying successful completion of a trained medication aid program for unlicensed personnel approved by the Minnesota Department of Health or comparable program, or biennially provide evidence of competency as demonstrated to a registered nurse ~~or~~, physician, or physician assistant.

(c) The license holder must have secure storage and safeguarding of all medications with storage of medications in their original container, know what information regarding medication administration must be reported to a health care professional, and must maintain a record of all medications administered.

Sec. 98. Minnesota Statutes 2020, section 245A.143, subdivision 8, is amended to read:

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

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

Sec. 99. Minnesota Statutes 2020, section 245A.1435, is amended to read:

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

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

(b) The license holder must place the infant in a crib directly on a firm mattress with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place anything in the crib with the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title 16, part 1511. The requirements of this section apply to license holders serving

infants younger than one year of age. Licensed child care providers must meet the crib requirements under section 245A.146. A correction order shall not be issued under this paragraph unless there is evidence that a violation occurred when an infant was present in the license holder's care.

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

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

Sec. 100. Minnesota Statutes 2020, section 245C.02, subdivision 18, is amended to read:

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

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

- (1) diagnostic testing, assessment, or observation;
- (2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or
- (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

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

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

Sec. 101. Minnesota Statutes 2020, section 245C.04, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family

adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B and:

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 102. Minnesota Statutes 2020, section 245D.02, subdivision 11, is amended to read:

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

- (1) serious injury of a person as determined by section 245.91, subdivision 6;
- (2) a person's death;
- (3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911; ~~physician or~~ advanced practice registered nurse, or physician assistant treatment; or hospitalization;
- (4) any mental health crisis that requires the program to call 911, a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate;
- (5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;
- (6) a person's unauthorized or unexplained absence from a program;
- (7) conduct by a person receiving services against another person receiving services that:
 - (i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;
 - (ii) places the person in actual and reasonable fear of harm;
 - (iii) places the person in actual and reasonable fear of damage to property of the person; or
 - (iv) substantially disrupts the orderly operation of the program;
- (8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14;
- (9) any emergency use of manual restraint as identified in section 245D.061 or successor provisions; or
- (10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.557 or chapter 260E.

Sec. 103. Minnesota Statutes 2020, section 245D.22, subdivision 7, is amended to read:

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

Sec. 104. Minnesota Statutes 2020, section 245D.25, subdivision 2, is amended to read:

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

Sec. 105. Minnesota Statutes 2020, section 245F.02, subdivision 13, is amended to read:

Subd. 13. **Medical director.** "Medical director" means an individual licensed in Minnesota by the Board of Medical Practice as a doctor of osteopathic medicine ~~or~~ physician, or physician assistant, or an individual licensed in Minnesota as an advanced practice registered nurse by the Board of Nursing and certified to practice as a clinical nurse specialist or nurse practitioner by a national nurse organization acceptable to the board. The medical director must be employed by or under contract with the license holder to direct and supervise health care for patients of a program licensed under this chapter.

Sec. 106. Minnesota Statutes 2020, section 245F.09, subdivision 2, is amended to read:

Subd. 2. **Protective procedures plan.** A license holder must have a written policy and procedure that establishes the protective procedures that program staff must follow when a patient is in imminent danger of harming self or others. The policy must be appropriate to the type of facility and the level of staff training. The protective procedures policy must include:

(1) an approval signed and dated by the program director and medical director prior to implementation. Any changes to the policy must also be approved, signed, and dated by the current program director and the medical director prior to implementation;

(2) which protective procedures the license holder will use to prevent patients from imminent danger of harming self or others;

(3) the emergency conditions under which the protective procedures are permitted to be used, if any;

(4) the patient's health conditions that limit the specific procedures that may be used and alternative means of ensuring safety;

(5) emergency resources the program staff must contact when a patient's behavior cannot be controlled by the procedures established in the policy;

(6) the training that staff must have before using any protective procedure;

(7) documentation of approved therapeutic holds;

(8) the use of law enforcement personnel as described in subdivision 4;

(9) standards governing emergency use of seclusion. Seclusion must be used only when less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii) must be met when seclusion is used with a patient:

(i) seclusion must be employed solely for the purpose of preventing a patient from imminent danger of harming self or others;

(ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm using projections, windows, electrical fixtures, or hard objects, and must allow the patient to be readily observed without being interrupted;

(iii) seclusion must be authorized by the program director, a licensed physician, ~~or~~ a registered nurse, or a licensed physician assistant. If one of these individuals is not present in the facility, the program director or a licensed physician ~~or~~, registered nurse, or physician assistant must be contacted and authorization must be obtained within 30 minutes of initiating seclusion, according to written policies;

(iv) patients must not be placed in seclusion for more than 12 hours at any one time;

(v) once the condition of a patient in seclusion has been determined to be safe enough to end continuous observation, a patient in seclusion must be observed at a minimum of every 15 minutes for the duration of seclusion and must always be within hearing range of program staff;

(vi) a process for program staff to use to remove a patient to other resources available to the facility if seclusion does not sufficiently assure patient safety; and

(vii) a seclusion area may be used for other purposes, such as intensive observation, if the room meets normal standards of care for the purpose and if the room is not locked; and

(10) physical holds may only be used when less restrictive measures are not feasible. The standards in items (i) to (iv) must be met when physical holds are used with a patient:

(i) physical holds must be employed solely for preventing a patient from imminent danger of harming self or others;

(ii) physical holds must be authorized by the program director, a licensed physician, ~~or~~ a registered nurse, or a physician assistant. If one of these individuals is not present in the facility, the program director or a licensed physician ~~or~~, registered nurse, or physician assistant must be contacted and authorization must be obtained within 30 minutes of initiating a physical hold, according to written policies;

(iii) the patient's health concerns must be considered in deciding whether to use physical holds and which holds are appropriate for the patient; and

(iv) only approved holds may be utilized. Prone holds are not allowed and must not be authorized.

Sec. 107. Minnesota Statutes 2020, section 245G.08, subdivision 2, is amended to read:

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

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

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

Sec. 108. Minnesota Statutes 2020, section 245G.08, subdivision 3, is amended to read:

Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone available for emergency treatment of opioid overdose must have a written standing order protocol by a physician who is

licensed under chapter 147 or advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of naloxone on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both.

Sec. 109. Minnesota Statutes 2020, section 245G.08, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 110. Minnesota Statutes 2020, section 245G.21, subdivision 2, is amended to read:

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

Sec. 111. Minnesota Statutes 2020, section 245G.21, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

Sec. 112. Minnesota Statutes 2020, section 245H.11, is amended to read:

245H.11 REPORTING.

(a) The certification holder must comply and must have written policies for staff to comply with the reporting requirements for abuse and neglect specified in chapter 260E. A person mandated to report physical or sexual child abuse or neglect occurring within a certified center shall report the information to the commissioner.

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

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

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

Sec. 113. Minnesota Statutes 2020, section 246.711, subdivision 2, is amended to read:

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

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

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

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

Sec. 114. Minnesota Statutes 2020, section 246.715, subdivision 2, is amended to read:

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

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

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

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

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

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

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

Sec. 115. Minnesota Statutes 2020, section 246.716, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 116. Minnesota Statutes 2020, section 246.721, is amended to read:

246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.

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

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

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

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

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

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

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

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

Sec. 117. Minnesota Statutes 2020, section 246.722, is amended to read:

246.722 IMMUNITY.

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

Sec. 118. Minnesota Statutes 2020, section 251.043, subdivision 1, is amended to read:

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

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

Sec. 119. Minnesota Statutes 2021 Supplement, section 252A.02, subdivision 12, is amended to read:

Subd. 12. **Comprehensive evaluation.** (a) "Comprehensive evaluation" consists of:

(1) a medical report on the health status and physical condition of the proposed person subject to public guardianship prepared under the direction of a licensed physician ~~or~~₂ advanced practice registered nurse, or physician assistant;

(2) a report on the intellectual capacity and functional abilities of the proposed person subject to public guardianship that specifies the tests and other data used in reaching its conclusions and is prepared by a psychologist who is qualified in the diagnosis of developmental disability; and

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

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

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

(iii) a description of contacts with and responses of near relatives of the proposed person subject to public guardianship notifying the near relatives that a nomination for public guardianship has been made and advising the near relatives that they may seek private guardianship.

(b) Each report under paragraph (a), clause (3), shall contain recommendations as to the amount of assistance and supervision required by the proposed person subject to public guardianship to function as independently as possible in society. To be considered part of the comprehensive evaluation, the reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 120. Minnesota Statutes 2021 Supplement, section 252A.04, subdivision 2, is amended to read:

Subd. 2. **Medication; treatment.** A proposed person subject to public guardianship who, at the time the comprehensive evaluation is to be performed, has been under medical care shall not be so under the influence or so suffer the effects of drugs, medication, or other treatment as to be hampered in the testing or evaluation process. When in the opinion of the licensed physician ~~or~~₂ advanced practice registered nurse₂ or physician assistant attending the proposed person subject to public guardianship, the discontinuance of medication or other treatment is not in the best interest of the proposed person subject to public guardianship, the physician ~~or~~₂ advanced practice registered nurse, or physician assistant shall record a list of all drugs, medication, or other treatment that the proposed person subject to public guardianship received 48 hours immediately prior to any examination, test, or interview conducted in preparation for the comprehensive evaluation.

Sec. 121. Minnesota Statutes 2021 Supplement, section 252A.20, subdivision 1, is amended to read:

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

Sec. 122. Minnesota Statutes 2020, section 253B.02, subdivision 9, is amended to read:

Subd. 9. **Health officer.** "Health officer" means:

- (1) a licensed physician;
- (2) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);
- (3) a licensed social worker;
- (4) a registered nurse working in an emergency room of a hospital;
- (5) an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3;
- (6) a physician assistant as defined in section 147A.01, subdivision 18;

~~(6)~~ (7) a mental health practitioner as defined in section 245.462, subdivision 17, providing mental health mobile crisis intervention services as described under section 256B.0624 with the consultation and approval by a mental health professional; or

~~(7)~~ (8) a formally designated member of a prepetition screening unit established by section 253B.07.

Sec. 123. Minnesota Statutes 2020, section 253B.03, subdivision 4, is amended to read:

Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a personal physician ~~or~~, advanced practice registered nurse, ~~or~~ physician assistant; spiritual advisor~~;~~₂; and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Sec. 124. Minnesota Statutes 2020, section 253B.03, subdivision 6d, is amended to read:

Subd. 6d. **Adult mental health treatment.** (a) A competent adult patient may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments. A declaration of preferences or instructions may include a health care directive under chapter 145C or a psychiatric directive.

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

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

(d) The physician, advanced practice registered nurse, physician assistant, or other provider shall make the declaration a part of the declarant's medical record. If the physician, advanced practice registered nurse, physician assistant, or other provider is unwilling at any time to comply with the declaration, the physician, advanced practice registered nurse, physician assistant, or provider must promptly notify the declarant and document the notification in the declarant's medical record. The physician, advanced practice registered nurse, physician assistant, or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as a person who poses a risk of harm due to mental illness or as a person who has a mental illness and is dangerous to the public and a court order authorizing the treatment has been issued or an emergency has been declared under section 253B.092, subdivision 3.

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

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

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

Sec. 125. Minnesota Statutes 2020, section 253B.06, subdivision 2, is amended to read:

Subd. 2. **Chemically dependent persons.** A treatment facility, state-operated treatment program, or community-based treatment program must examine a patient hospitalized as chemically dependent pursuant to section 253B.04 or 253B.051 within 48 hours of admission. At a minimum, the facility or program must physically examine the patient according to procedures established by a physician or advanced practice registered nurse, or physician assistant, and staff examining the patient must be knowledgeable and trained in the diagnosis of the alleged disability forming the basis of the patient's admission as a chemically dependent person.

Sec. 126. Minnesota Statutes 2020, section 253B.23, subdivision 4, is amended to read:

Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to this chapter, are not subject to any civil

or criminal liability under this chapter. Any privilege otherwise existing between patient and physician, patient and advanced practice registered nurse, patient and registered nurse, patient and physician assistant, patient and psychologist, patient and examiner, or patient and social worker, is waived as to any physician, advanced practice registered nurse, registered nurse, physician assistant, psychologist, examiner, or social worker who provides information with respect to a patient pursuant to any provision of this chapter.

Sec. 127. Minnesota Statutes 2020, section 254A.08, subdivision 2, is amended to read:

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

Sec. 128. Minnesota Statutes 2020, section 256.9685, subdivision 1a, is amended to read:

Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04, subdivision 15, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician, advanced practice registered nurse, physician assistant, or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by the medical review agent that is independent of the case under reconsideration.

Sec. 129. Minnesota Statutes 2020, section 256.9685, subdivision 1b, is amended to read:

Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary after the reconsideration and determinations. A physician, advanced practice registered nurse, physician assistant, or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review.

Sec. 130. Minnesota Statutes 2020, section 256.9685, subdivision 1c, is amended to read:

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

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

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

Sec. 131. Minnesota Statutes 2020, section 256.975, subdivision 7a, is amended to read:

Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a) All individuals seeking admission to Medicaid-certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the need for nursing facility level of care as described in section 256B.0911, subdivision 4e, and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

(c) The following criteria apply to the preadmission screening:

(1) requests for preadmission screenings must be submitted via an online form developed by the commissioner;

(2) the Senior LinkAge Line must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(3) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(d) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(e) In assessing a person's needs, the screener shall:

(1) use an automated system designated by the commissioner;

(2) consult with care transitions coordinators, physician, ~~or~~ advanced practice registered nurse, or physician assistant; and

(3) consider the assessment of the individual's physician ~~or~~ advanced practice registered nurse, or physician assistant.

Other personnel may be included in the level of care determination as deemed necessary by the screener.

Sec. 132. Minnesota Statutes 2020, section 256.975, subdivision 7b, is amended to read:

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician ~~or~~ advanced practice registered nurse, or physician assistant has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician ~~or~~ advanced practice registered nurse, or physician assistant has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

(e) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in section 256B.0911, subdivision 1a. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 133. Minnesota Statutes 2020, section 256.975, subdivision 11, is amended to read:

Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging shall award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

(b) The project areas for grants include:

(1) local or community-based initiatives to promote the benefits of physician ~~or~~, advanced practice registered nurse, or physician assistant consultations for all individuals who suspect a memory or cognitive problem;

(2) local or community-based initiatives to promote the benefits of early diagnosis of Alzheimer's disease and other dementias; and

(3) local or community-based initiatives to provide informational materials and other resources to caregivers of persons with dementia.

(c) Eligible applicants for local and regional grants may include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations.

(d) Applicants must:

(1) describe the proposed initiative, including the targeted community and how the initiative meets the requirements of this subdivision; and

(2) identify the proposed outcomes of the initiative and the evaluation process to be used to measure these outcomes.

(e) In awarding the regional and local dementia grants, the Minnesota Board on Aging must give priority to applicants who demonstrate that the proposed project:

(1) is supported by and appropriately targeted to the community the applicant serves;

(2) is designed to coordinate with other community activities related to other health initiatives, particularly those initiatives targeted at the elderly;

(3) is conducted by an applicant able to demonstrate expertise in the project areas;

(4) utilizes and enhances existing activities and resources or involves innovative approaches to achieve success in the project areas; and

(5) strengthens community relationships and partnerships in order to achieve the project areas.

(f) The board shall divide the state into specific geographic regions and allocate a percentage of the money available for the local and regional dementia grants to projects or initiatives aimed at each geographic region.

(g) The board shall award any available grants by January 1, 2016, and each July 1 thereafter.

(h) Each grant recipient shall report to the board on the progress of the initiative at least once during the grant period, and within two months of the end of the grant period shall submit a final report to the board that includes the outcome results.

(i) The Minnesota Board on Aging shall:

(1) develop the criteria and procedures to allocate the grants under this subdivision, evaluate all applicants on a competitive basis and award the grants, and select qualified providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training; and

(2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on the dementia grants programs under this subdivision to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over health finance and policy. The report shall include:

(i) information on each grant recipient;

(ii) a summary of all projects or initiatives undertaken with each grant;

(iii) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation; and

(iv) an accounting of how the grant funds were spent.

Sec. 134. Minnesota Statutes 2020, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification

of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by (1) the parent or guardian, (2) the child's physician or

physicians or, advanced practice registered nurse or advanced practice registered nurses, or physician assistant or physician assistants, and (3) other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Sec. 135. Minnesota Statutes 2020, section 256B.0575, subdivision 1, is amended to read:

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

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

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

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

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

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

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

in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

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

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

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

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

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

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

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

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

(3) if one of the following circumstances apply:

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

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

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

Sec. 136. Minnesota Statutes 2020, section 256B.0595, subdivision 3, is amended to read:

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the Supplemental Security Income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date the individual became an institutionalized person, and who provided care to the individual that, as certified by the individual's attending physician ~~or~~, advanced practice registered nurse, or physician assistant, permitted the individual to reside at home rather than receive care in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services provided within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(3) 36 months if transferred in any other manner after August 10, 1993, but prior to February 8, 2006;
or

(4) 60 months if the homestead was transferred on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action.

Sec. 137. Minnesota Statutes 2020, section 256B.0622, subdivision 2b, is amended to read:

Subd. 2b. **Continuing stay and discharge criteria for assertive community treatment.** (a) A client receiving assertive community treatment is eligible to continue receiving services if:

(1) the client has not achieved the desired outcomes of their individual treatment plan;

(2) the client's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(3) the client continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; or

(4) the client is functioning effectively with this service and discharge would otherwise be indicated but without continued services the client's functioning would decline; and

(5) one of the following must also apply:

(i) the client has achieved current individual treatment plan goals but additional goals are indicated as evidenced by documented symptoms;

(ii) the client is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the individual treatment plan;

(iii) the client is making progress, but the specific interventions in the individual treatment plan need to be modified so that greater gains, which are consistent with the client's potential level of functioning, are possible; or

(iv) the client fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the individual treatment plan.

(b) Clients receiving assertive community treatment are eligible to be discharged if they meet at least one of the following criteria:

(1) the client and the ACT team determine that assertive community treatment services are no longer needed based on the attainment of goals as identified in the individual treatment plan and a less intensive level of care would adequately address current goals;

(2) the client moves out of the ACT team's service area and the ACT team has facilitated the referral to either a new ACT team or other appropriate mental health service and has assisted the individual in the transition process;

(3) the client, or the client's legal guardian when applicable, chooses to withdraw from assertive community treatment services and documented attempts by the ACT team to re-engage the client with the service have not been successful;

(4) the client has a demonstrated need for a medical nursing home placement lasting more than three months, as determined by a physician ~~or~~, advanced practice registered nurse, or physician assistant;

(5) the client is hospitalized, in residential treatment, or in jail for a period of greater than three months. However, the ACT team must make provisions for the client to return to the ACT team upon their discharge or release from the hospital or jail if the client still meets eligibility criteria for assertive community treatment and the team is not at full capacity;

(6) the ACT team is unable to locate, contact, and engage the client for a period of greater than three months after persistent efforts by the ACT team to locate the client; or

(7) the client requests a discharge, despite repeated and proactive efforts by the ACT team to engage the client in service planning. The ACT team must develop a transition plan to arrange for alternate treatment for clients in this situation who have a history of suicide attempts, assault, or forensic involvement.

(c) For all clients who are discharged from assertive community treatment to another service provider within the ACT team's service area there is a three-month transfer period, from the date of discharge, during which a client who does not adjust well to the new service, may voluntarily return to the ACT team. During this period, the ACT team must maintain contact with the client's new service provider.

Sec. 138. Minnesota Statutes 2020, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. **Skilled and intermediate nursing care.** (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician or advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Sec. 139. Minnesota Statutes 2020, section 256B.0625, subdivision 12, is amended to read:

Subd. 12. **Eyeglasses, dentures, and prosthetic and orthotic devices.** (a) Medical assistance covers eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed practitioner.

(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner" includes a physician, an advanced practice registered nurse, a physician assistant, or a podiatrist.

Sec. 140. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

- (1) nonemergency medical transportation providers who meet the requirements of this subdivision;
- (2) ambulances, as defined in section 144E.001, subdivision 2;
- (3) taxicabs that meet the requirements of this subdivision;
- (4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (h).

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed,

made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) \$0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency medical transportation provider;

(4) \$13 for the base rate and \$1.30 per mile for assisted transport;

(5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

(6) \$75 for the base rate and \$2.40 per mile for protected transport; and

(7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

Sec. 141. Minnesota Statutes 2020, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary in making a determination for eligibility for individualized education program and individualized family service plan services and for medical services identified in a recipient's individualized education program and individualized family service plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individualized education program be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity; physician's ~~or~~ advanced practice registered nurse's, or physician assistant's orders; documentation; personnel qualifications; and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individualized education program are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individualized education program does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician ~~or~~ advanced practice registered nurse, or physician assistant review and approval of the plan not more than once annually or upon any modification of the individualized education program that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Professional Educator Licensing and Standards Board as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individualized education program or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Sec. 142. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, ~~who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry,~~ may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their education, training, and experience, authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments ~~or providing treatment supervision.~~

Sec. 143. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has received a

certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, physician assistant, mental health professional, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 144. Minnesota Statutes 2020, section 256B.0625, subdivision 60a, is amended to read:

Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a community emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician ~~or~~, advanced practice registered nurse, or physician assistant. The postdischarge visit includes:

- (1) verbal or visual reminders of discharge orders;
- (2) recording and reporting of vital signs to the patient's primary care provider;
- (3) medication access confirmation;
- (4) food access confirmation; and
- (5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

- (1) medication access confirmation;
- (2) food access confirmation; and
- (3) identification of home hazards.

(d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a postdischarge visit for the same individual.

Sec. 145. Minnesota Statutes 2020, section 256B.0659, subdivision 2, is amended to read:

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

- (1) activities of daily living;
- (2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with helping recipient with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, advanced practice registered nurse, ~~certified or licensed~~ respiratory therapist, physician assistant, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Sec. 146. Minnesota Statutes 2020, section 256B.0659, subdivision 4, is amended to read:

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician ~~or~~, advanced practice registered nurse, or physician assistant; specified in a personal care assistance care plan or community support plan developed under section 256B.0911; and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

- (iii) requiring sterile or clean dressing changes or a wound vac; or
 - (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;
 - (3) parenteral therapy described as:
 - (i) IV therapy more than two times per week lasting longer than four hours for each treatment; or
 - (ii) total parenteral nutrition (TPN) daily;
 - (4) respiratory interventions, including:
 - (i) oxygen required more than eight hours per day;
 - (ii) respiratory vest more than one time per day;
 - (iii) bronchial drainage treatments more than two times per day;
 - (iv) sterile or clean suctioning more than six times per day;
 - (v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and
 - (vi) ventilator dependence under section 256B.0652;
 - (5) insertion and maintenance of catheter, including:
 - (i) sterile catheter changes more than one time per month;
 - (ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or
 - (iii) bladder irrigations;
 - (6) bowel program more than two times per week requiring more than 30 minutes to perform each time;
 - (7) neurological intervention, including:
 - (i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or
 - (ii) swallowing disorders diagnosed by a physician ~~or~~, advanced practice registered nurse, or physician assistant and requiring specialized assistance from another on a daily basis; and
 - (8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.
- (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:
- (1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;
 - (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or
 - (3) increased need for assistance for recipients who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

Sec. 147. Minnesota Statutes 2020, section 256B.0659, subdivision 8, is amended to read:

Subd. 8. **Communication with recipient's physician ~~or~~, advanced practice registered nurse, or physician assistant.** The personal care assistance program requires communication with the recipient's physician ~~or~~, advanced practice registered nurse, or physician assistant about a recipient's assessed needs for personal care assistance services. The commissioner shall work with the state medical director to develop options for communication with the recipient's physician ~~or~~, advanced practice registered nurse, or physician assistant.

Sec. 148. Minnesota Statutes 2021 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional, physician, ~~or~~ advanced practice registered nurse, or physician assistant;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices,

fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides covered services to a recipient who qualifies for ten or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

Sec. 149. Minnesota Statutes 2020, section 256B.0659, subdivision 27, is amended to read:

Subd. 27. **Personal care assistance provider agency.** (a) The personal care assistance provider agency is required to provide training for the personal care assistant responsible for working with a recipient who is ventilator dependent. All training must be administered by a respiratory therapist, nurse, physician assistant, or physician. Qualified professional supervision by a nurse must be completed and documented on file in the personal care assistant's employment record and the recipient's health record. If offering personal care services to a ventilator-dependent recipient, the personal care assistance provider agency shall demonstrate and document the ability to:

(1) train the personal care assistant;

(2) supervise the personal care assistant in the care of a ventilator-dependent recipient;

(3) supervise the recipient and responsible party in the care of a ventilator-dependent recipient; and

(4) provide documentation of the training and supervision in clauses (1) to (3) upon request.

(b) A personal care assistant shall not undertake any clinical services, patient assessment, patient evaluation, or clinical education regarding the ventilator or the patient on the ventilator. These services may only be provided by health care professionals licensed or registered in this state.

(c) A personal care assistant may only perform tasks associated with ventilator maintenance that are approved by the Board of Medical Practice in consultation with the Respiratory Care Practitioner Advisory Council and the Department of Human Services.

Sec. 150. Minnesota Statutes 2020, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256S.10. The plan shall include any services prescribed by the individual's attending physician ~~or~~ advanced practice registered nurse, or physician assistant as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the coordinated service and support plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 151. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

- (1) individual, family, and group psychotherapy;
- (2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);
- (3) crisis planning as defined in section 245.4871, subdivision 9a;
- (4) medication management provided by a physician ~~or~~ an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant;
- (5) mental health case management as provided in section 256B.0625, subdivision 20;
- (6) medication education services as defined in this section;
- (7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;
- (8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;
- (9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

Sec. 152. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician ~~or~~ advanced practice registered nurse, or physician assistant or (ii) a mental health professional; and

(3) meet the requirements of a standard diagnostic assessment according to section 245I.10, subdivision 6.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 153. Minnesota Statutes 2020, section 256B.0949, subdivision 5, is amended to read:

Subd. 5. **Comprehensive multidisciplinary evaluation.** (a) A CMDE must be completed to determine medical necessity of EIDBI services. For the commissioner to authorize EIDBI services, the CMDE provider must submit the CMDE to the commissioner and the person or the person's legal representative as determined by the commissioner. Information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the person.

(b) The CMDE provider must review the diagnostic assessment to confirm the person has an eligible diagnosis and the diagnostic assessment meets standards required under subdivision 4. If the CMDE provider elects to complete the diagnostic assessment at the same time as the CMDE, the CMDE provider must certify that the CMDE meets all standards as required under subdivision 4.

(c) The CMDE must:

(1) include an assessment of the person's developmental skills, functional behavior, needs, and capacities based on direct observation of the person which must be administered by a CMDE provider, include medical or assessment information from the person's physician ~~or~~ advanced practice registered nurse, or physician

assistant, and may also include input from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation or habilitation therapists, licensed school personnel, or mental health professionals;

(2) include and document the person's legal representative's or primary caregiver's preferences for involvement in the person's treatment; and

(3) provide information about the range of current EIDBI treatment modalities recognized by the commissioner.

Sec. 154. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, an advanced practice registered nurse, a physician assistant, a mental health professional, or a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 155. Minnesota Statutes 2020, section 256B.73, subdivision 5, is amended to read:

Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider shall receive a health services benefit package that includes health services which the enrollees might reasonably require to be maintained in good health, including emergency care;~~;~~ inpatient hospital and physician ~~or~~~~;~~ advanced practice registered nurse, or physician assistant care;~~;~~ outpatient health services;~~;~~ and preventive health services.

(b) Services related to chemical dependency, mental illness, vision care, dental care, and other benefits may be excluded or limited upon approval by the commissioners. The coalition may petition the commissioner of commerce or health, whichever is appropriate, for waivers that allow these benefits to be excluded or limited.

(c) The commissioners, the coalition, and demonstration providers shall work together to design a package of benefits or packages of benefits that can be provided to enrollees for an affordable monthly premium.

Sec. 156. Minnesota Statutes 2021 Supplement, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent

clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, advanced practice registered nurse, physician assistant, or qualified mental health professional under section 245I.04, subdivision 2.

(d) For substance use disorder, a "qualified professional" means a licensed physician, a licensed physician assistant, a qualified mental health professional under section 245.462, subdivision 18, clauses (1) to (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

Sec. 157. Minnesota Statutes 2020, section 256R.44, is amended to read:

256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.

(a) The amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician ~~or~~ advanced practice registered nurse, or physician assistant and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

(b) For a nursing facility with a total property payment rate determined under section 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

Sec. 158. Minnesota Statutes 2020, section 256R.54, subdivision 1, is amended to read:

Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The commissioner shall adopt rules under the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

(b) Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer.

(c) Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician ~~or~~ advanced practice registered nurse, or physician assistant cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's ~~or~~ advanced practice registered nurse's, or physician assistant's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed

against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for services not medically necessary.

(d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) For purposes of this subdivision, "ancillary services" includes transportation defined as a covered service in section 256B.0625, subdivision 17.

Sec. 159. Minnesota Statutes 2020, section 256R.54, subdivision 2, is amended to read:

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician or advanced practice registered nurse, or physician assistant and the treatment plan. If the recipient's medical record does not include these documents, the commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing facility for inclusion in the recipient's medical record. The commissioner shall make recommendations regarding the medical necessity of services provided.

Sec. 160. Minnesota Statutes 2020, section 257.63, subdivision 3, is amended to read:

Subd. 3. **Medical privilege.** Testimony of a physician or advanced practice registered nurse, or physician assistant concerning the medical circumstances of the pregnancy itself and the condition and characteristics of the child upon birth is not privileged.

Sec. 161. Minnesota Statutes 2020, section 257B.01, subdivision 3, is amended to read:

Subd. 3. **Attending physician or advanced practice registered nurse, or physician assistant.** "Attending physician or advanced practice registered nurse, or physician assistant" means a physician or advanced practice registered nurse, or physician assistant who has primary responsibility for the treatment and care of the designator. If physicians or advanced practice registered nurses, or physician assistants share responsibility; another physician or advanced practice registered nurse, or physician assistant is acting on the attending physician's or advanced practice registered nurse's, or physician assistant's behalf; or no physician or advanced practice registered nurse, or physician assistant has primary responsibility, any physician or advanced practice registered nurse, or physician assistant who is familiar with the designator's medical condition may act as an attending physician or advanced practice registered nurse, or physician assistant under this chapter.

Sec. 162. Minnesota Statutes 2020, section 257B.01, subdivision 9, is amended to read:

Subd. 9. **Determination of debilitation.** "Determination of debilitation" means a written finding made by an attending physician or advanced practice registered nurse, or physician assistant which states that the

designator suffers from a physically incapacitating disease or injury. No identification of the illness in question is required.

Sec. 163. Minnesota Statutes 2020, section 257B.01, subdivision 10, is amended to read:

Subd. 10. **Determination of incapacity.** "Determination of incapacity" means a written finding made by an attending physician ~~or~~, advanced practice registered nurse, or physician assistant which states the nature, extent, and probable duration of the designator's mental or organic incapacity.

Sec. 164. Minnesota Statutes 2020, section 257B.06, subdivision 7, is amended to read:

Subd. 7. **Restored capacity.** If a licensed physician ~~or~~, advanced practice registered nurse, or physician assistant determines that the designator has regained capacity, the co-custodian's authority that commenced on the occurrence of a triggering event becomes inactive. Failure of a co-custodian to immediately return the child(ren) to the designator's care entitles the designator to an emergency hearing within five days of a request for a hearing.

Sec. 165. Minnesota Statutes 2020, section 259.24, subdivision 2, is amended to read:

Subd. 2. **Parents, guardian.** If an unmarried parent who consents to the adoption of a child is under 18 years of age, the consent of the minor parent's parents or guardian, if any, also shall be required; if either or both the parents are disqualified for any of the reasons enumerated in subdivision 1, the consent of such parent shall be waived, and the consent of the guardian only shall be sufficient; and, if there be neither parent nor guardian qualified to give such consent, the consent may be given by the commissioner. The agency overseeing the adoption proceedings shall ensure that the minor parent is offered the opportunity to consult with an attorney, a member of the clergy, a physician, ~~or~~ an advanced practice registered nurse, or a physician assistant before consenting to adoption of the child. The advice or opinion of the attorney, clergy member, ~~physician, or~~ advanced practice registered nurse, or physician assistant shall not be binding on the minor parent. If the minor parent cannot afford the cost of consulting with an attorney, a member of the clergy, a physician, ~~or~~ an advanced practice registered nurse, or a physician assistant, the county shall bear that cost.

Sec. 166. Minnesota Statutes 2020, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 260E.03, subdivision 18 or 20, (ii) resides with or has resided with a victim of child abuse as defined in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from an infant with a disability with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's or advanced practice registered nurse's, or physician assistant's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or advanced practice registered nurse's, or physician assistant's reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ten years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.503, subdivision 2, is not in the best interests of the child.

Sec. 167. Minnesota Statutes 2020, section 383A.13, subdivision 3, is amended to read:

Subd. 3. **May do these actions.** Paramedics may do any of the following:

- (a) perform regular rescue, first aid and resuscitation services;
- (b) during training administer parenteral medications under the direct supervision of a licensed physician ~~or~~, a registered nurse, or a licensed physician assistant;
- (c) perform cardiopulmonary resuscitation and defibrillation in a pulseless, nonbreathing patient;
- (d) administer intravenous saline or glucose solutions;
- (e) administer parenteral injections in any of the following classes of drugs:
 - (i) antiarrhythmic agents;
 - (ii) vagolytic agents;
 - (iii) chronotropic agents;
 - (iv) analgesic agents;
 - (v) alkalinizing agents;
 - (vi) vasopressor agents;
 - (vii) diuretics;
- (f) administer, perform and apply all other (f) procedures, drugs and skills in which they have been trained and are certified to give, apply and dispense.

Sec. 168. Minnesota Statutes 2020, section 383A.13, subdivision 6, is amended to read:

Subd. 6. **No civil liability of doctors ~~and~~, nurses, and physician assistants; conditions.** No licensed physician ~~or~~, registered nurse, or licensed physician assistant, who in good faith and in the exercise of reasonable care gives emergency instructions to a certified paramedic at the scene of an emergency, or while in transit to and from the scene of such emergency, shall be liable for any civil damages as a result of issuing such instructions.

Sec. 169. Minnesota Statutes 2020, section 609.341, subdivision 17, is amended to read:

Subd. 17. **Psychotherapist.** "Psychotherapist" means a person who is or purports to be a physician, psychologist, nurse, physician assistant, chemical dependency counselor, social worker, marriage and family therapist, licensed professional counselor, or other mental health service provider; or any other person, whether or not licensed by the state, who performs or purports to perform psychotherapy.

Sec. 170. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "certified nurse practitioner," "nurse practitioner," or similar terms to "advanced practice registered nurse" wherever the terms appear in Minnesota Statutes and Minnesota Rules. The revisor may make grammatical changes related to the term change.

Sec. 171. **REPEALER.**

Minnesota Statutes 2020, sections 147A.01, subdivision 23; and 151.37, subdivision 2a, are repealed.

Presented to the governor May 17, 2022

Signed by the governor May 19, 2022, 1:45 p.m.