..... moves to amend H.F. No. 1914, the first engrossment, as follows:

Page 6, delete section 4 and insert:

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

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

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

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

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

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

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

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

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

(1) activities permitted under paragraph (b);

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

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

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

Page 9, delete section 8 and insert:

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

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

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

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

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

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered drugs and ~~physician-administered~~ drugs that are administered by a physician or advanced practice registered nurse, 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."

Page 25, delete section 35 and insert:

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

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

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

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

Page 43, delete section 69 and insert:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Page 55, delete section 77

Page 56, delete section 78

Page 65, delete section 88 and insert:

"Sec. 88. Minnesota Statutes 2019 Supplement, section 245G.08, subdivision 3, is amended to read:

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

Page 68, delete sections 92 and 93

Page 69, delete sections 94 and 95

Page 70, delete section 96

Page 72, delete section 97 and insert:

"Sec. 97. Minnesota Statutes 2019 Supplement, section 245H.11, is amended to read:

245H.11 REPORTING.

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

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

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

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

Page 90, delete section 127

Page 97, delete section 132

Page 100, delete sections 134 and 135

Page 101, delete section 136 and insert:

"Sec. 136. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to read:

Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by a licensed practitioner.

(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner" includes a physician, an advanced practice registered nurse, or a podiatrist.

Sec. 137. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or ~~a nurse practitioner~~ advanced

practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

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

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

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

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

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

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

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and

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

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

Page 103, delete section 137 and insert:

"Sec. 138. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the

operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2)."

Page 110, delete section 140 and insert:

"Sec. 140. Minnesota Statutes 2019 Supplement, section 256B.0625, subdivision 60a, is amended to read:

Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a community emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician or advanced practice registered nurse. The postdischarge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a postdischarge visit for the same individual."

Page 120, delete section 148 and insert:

"Sec. 148. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional ~~or~~, physician, or advanced practice registered nurse;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides covered services to a recipient who qualifies for 12 or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements."

Page 121, delete section 149 and insert:

"Sec. 149. Minnesota Statutes 2019 Supplement, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256S.10. The plan shall include any services prescribed by the individual's attending physician or advanced practice registered nurse as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case

manager shall provide documentation in each individual's plan and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the coordinated service and support plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds."

Page 124, delete section 152 and insert:

"Sec. 152. Minnesota Statutes 2019 Supplement, section 256R.44, is amended to read:

256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.

(a) The amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician or advanced practice registered nurse and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

(b) For a nursing facility with a total property payment rate determined under section 256R.26, subdivision 8, the amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition. Conditions requiring a private room must be determined by the resident's attending physician or advanced practice registered nurse and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity."

Page 126, after line 25, insert:

"Sec. 160. **REPEALER.**

Minnesota Rules, part 9505.0365, subpart 3, is repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly