..... moves to amend H.F. No. 4706 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DEPARTMENT OF HEALTH FINANCE

Section 1. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

Subdivision 1. **Requirements.** (a) Each health provider and health facility shall comply with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted under that act, to the extent that it imposes requirements that apply in this state but are not required under the laws of this state. This section does not require compliance with any provision of the No Surprises Act before January 1, 2022.

(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2. **Compliance and investigations.** (a) The commissioner of health shall, to the extent practicable, seek the cooperation of health care providers and facilities in obtaining compliance with this section.

(b) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner of health. Complaints filed under this section must be filed in writing, either on paper or electronically. The commissioner may prescribe additional procedures for the filing of complaints.

(c) The commissioner may also conduct compliance reviews to determine whether health care providers and facilities are complying with this section.

(d) The commissioner will investigate complaints filed under this section. The commissioner may prioritize complaint investigations, compliance reviews, and the collection of any possible civil monetary penalties under paragraph (g), clause (2), based on factors such as repeat complaints or violations, the seriousness of the complaint or violation, and other factors as determined by the commissioner.

(e) The commissioner shall inform the health care provider or facility of the complaint or findings of a compliance review and shall provide an opportunity for the health care provider or facility to submit information the health care provider or facility considers relevant to further review and investigation of the complaint or the findings of the compliance review. The health care provider or facility must submit any such information to the commissioner within 30 days of receipt of notification of a complaint or compliance review under this section.

(f) If, after reviewing any information described in paragraph (e) and the results of any investigation, the commissioner determines that the provider or facility has not violated this section, the commissioner shall notify the provider or facility as well as any relevant complainant.

(g) If, after reviewing any information described in paragraph (e) and the results of any investigation, the commissioner determines that the provider or facility is in violation of this section, the commissioner shall notify the provider or facility and take the following steps:

(1) in cases of noncompliance with this section, the commissioner shall first attempt to achieve compliance through successful remediation on the part of the noncompliant provider or facility including completion of a corrective action plan or other agreement; and

(2) if, after taking the action in clause (1) compliance has not been achieved, the commissioner of health shall notify the provider or facility that the provider or facility is in violation of this section and that the commissioner is imposing a civil monetary penalty. If the commissioner determines that more than one health care provider or facility was responsible for a violation, the commissioner may impose a civil money penalty against each health care provider or facility. The amount of a civil money penalty shall be up to $100 for each violation, but shall not exceed $25,000 for identical violations during a calendar year; and

(3) no civil money penalty shall be imposed under this section for violations that occur prior to January 1, 2023. Warnings must be issued and any compliance issues must be

referred to the federal government for enforcement pursuant to the federal No Surprises Act or other applicable federal laws and regulations.

(h) A health care provider or facility may contest whether the finding of facts constitute a violation of this section according to the contested case proceeding in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(i) When steps in paragraphs (b) to (h) have been completed as needed, the commissioner shall notify the health care provider or facility and, if the matter arose from a complaint, the complainant regarding the disposition of complaint or compliance review.

(j) Any data collected by the commissioner of health as part of an active investigation or active compliance review under this section are classified as protected nonpublic data pursuant to section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final disposition of an investigation or compliance review are classified as public.

(k) Civil money penalties imposed and collected under this subdivision shall be deposited into the general fund and are appropriated to the commissioner of health for the purposes of this section, including the provision of compliance reviews and technical assistance.

(l) Any compliance and investigative action taken by the department under this section shall only include potential violations that occur on or after the effective date of this section.

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

Sec. 2. Minnesota Statutes 2020, section 62Q.021, is amended by adding a subdivision to read:

Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider, and health facility shall comply with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted under that act, to the extent that it imposes requirements that apply in this state but are not required under the laws of this state. This section does not require compliance with any provision of the No Surprises Act before the effective date provided for that provision in the Consolidated Appropriations Act. The commissioner shall enforce this subdivision.

Sec. 3. Minnesota Statutes 2020, section 62Q.55, subdivision 5, is amended to read:

Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company

shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network and shall count toward the in-network deductible. All coverage and charges for emergency services must comply with all requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

Sec. 4. Minnesota Statutes 2020, section 62Q.556, is amended to read:

62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

Subdivision 1. **~~Unauthorized provider services~~ Nonparticipating provider balance billing prohibition.** (a) Except as provided in paragraph ~~(c)~~ (b), ~~unauthorized provider services occur~~ balance billing is prohibited when an enrollee receives services:

(1) from a nonparticipating provider at a participating hospital or ambulatory surgical center, ~~when the services are rendered:~~ as described by Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act;

~~(i) due to the unavailability of a participating provider;~~

~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

~~(iii) due to the need for unforeseen services arising at the time the services are being rendered; or~~

(2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility~~.~~; or

~~(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.~~

(3) from a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

~~(c)~~ (b) The services described in paragraph (a), ~~clause~~ clauses (1) and (2), as defined in Division BB, Title I of the Consolidated Appropriations Act, 2021, and any federal

regulations adopted under that act, are ~~not unauthorized provider services~~ subject to balance billing if the enrollee ~~gives advance written~~ informed consent ~~to the~~ prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

Subd. 2. ~~**Prohibition**~~ **Cost-sharing requirements and independent dispute resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company ~~must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties~~ and nonparticipating provider shall initiate open negotiations of disputed amounts. If there is no agreement, either party may initiate the federal independent dispute resolution process pursuant to Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

~~(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the Department of Health website, and update the list as appropriate.~~

~~(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on~~

~~information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.~~

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2023, a health plan company must report annually to the commissioner:

(1) the total number of claims and total billed and paid amount for nonparticipating provider services, by service and provider type, submitted to the health plan in the prior calendar year; and

(2) the total number of enrollee complaints received regarding the rights and protections established by Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act, in the prior calendar year.

(b) The commissioners of commerce and health may develop the form and manner for health plan companies to comply with paragraph (a).

Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act is subject to the requirements of this section.

(b) The commissioner of commerce or health may enforce this section.

(c) If the commissioner of health has cause to believe that any hospital or facility licensed under chapter 144 has violated this section, the commissioner may investigate, examine, and otherwise enforce this section pursuant to chapter 144 or may refer the potential violation to the relevant licensing board with regulatory authority over the provider.

(d) If a health-related licensing board has cause to believe that a provider has violated this section, it may further investigate and enforce the provisions of this section pursuant to chapter 214.

Sec. 5. Minnesota Statutes 2020, section 62Q.56, subdivision 2, is amended to read:

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy ~~beyond the first trimester of pregnancy~~;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Sec. 6. 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 and any applicable state and federal law.

(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 medical records, the attending physician, advanced practice registered nurse, or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Sec. 7. Minnesota Statutes 2020, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Non-claims-based payments.** (a) Beginning in 2024, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all non-claims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Non-claims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments. Non-claims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses of health care spending.

(b) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner

shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

(c) The commissioner shall consult with health plan companies, hospitals, and health care providers in developing the data reported under this subdivision and standardized reporting forms.

Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

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

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2020, section 62U.10, subdivision 7, is amended to read:

Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1, 2016, and~~ Each November 1 ~~thereafter~~, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 ~~and~~, 5, and 5b, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Sec. 10. **[115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND WASTEWATER TREATMENT FACILITIES.**

Subdivision 1. **Purpose; membership.** The advisory council on water supply systems and wastewater treatment facilities shall advise the commissioners of health and the Pollution Control Agency regarding classification of water supply systems and wastewater treatment facilities, qualifications and competency evaluation of water supply system operators and wastewater treatment facility operators, and additional laws, rules, and procedures that may be desirable for regulating the operation of water supply systems and of wastewater treatment facilities. The advisory council is composed of 11 voting members, of whom:

(1) one member must be from the Department of Health, Division of Environmental Health, appointed by the commissioner of health;

(2) one member must be from the Pollution Control Agency, appointed by the commissioner of the Pollution Control Agency;

(3) three members must be certified water supply system operators, appointed by the commissioner of health, one of whom must represent a nonmunicipal community or nontransient noncommunity water supply system;

(4) three members must be certified wastewater treatment facility operators, appointed by the commissioner of the Pollution Control Agency;

(5) one member must be a representative from an organization representing municipalities, appointed by the commissioner of health with the concurrence of the commissioner of the Pollution Control Agency; and

(6) two members must be members of the public who are not associated with water supply systems or wastewater treatment facilities. One must be appointed by the commissioner of health and the other by the commissioner of the Pollution Control Agency. Consideration should be given to one of these members being a representative of academia knowledgeable in water or wastewater matters.

Subd. 2. **Geographic representation.** At least one of the water supply system operators and at least one of the wastewater treatment facility operators must be from outside the seven-county metropolitan area, and one wastewater treatment facility operator must be from the Metropolitan Council.

Subd. 3. **Terms; compensation.** The terms of the appointed members and the compensation and removal of all members are governed by section 15.059.

Subd. 4. **Officers.** When new members are appointed to the council, a chair must be elected at the next council meeting. The Department of Health representative shall serve as secretary of the council.

Sec. 11. Minnesota Statutes 2020, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, supervised living facilities, assisted living facilities, and assisted living facilities with dementia care at the following levels:

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.
Assisted living facilities with dementia care	$3,000 plus $100 per resident.
Assisted living facilities	$2,000 plus $75 per resident.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$	900
Swing bed surveys for nursing homes	$	1,200
Psychiatric hospitals	$	1,400
Rural health facilities	$	1,100
Portable x-ray providers	$	500
Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800

Hospitals		$ 4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

(f) Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed on assisted living facilities and assisted living facilities with dementia care under paragraph (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

(1) a facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent lower than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise more than 50 percent of the facility's capacity in the calendar year prior to the year in which the renewal application is submitted; and

(2) a facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent higher than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise less than 50 percent of the facility's capacity during the calendar year prior to the year in which the renewal application is submitted.

The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a method for determining capacity thresholds in this paragraph in consultation with the commissioner of human services and must coordinate the administration of this paragraph with the commissioner of human services for purposes of verification.

(g) The commissioner shall charge hospitals an annual licensing base fee of $1,150 per hospital, plus an additional $15 per licensed bed/bassinet fee. Revenue shall be deposited to the state government special revenue fund and credited toward trauma hospital designations under sections 144.605 and 144.6071.

Sec. 12. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Acupuncture practitioner" means an individual licensed to practice acupuncture under chapter 147B.

~~(b)~~ (c) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106.

(d) "Advanced practice provider" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(c)~~ (e) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and drug counselor under chapter 148F.

~~(d)~~ (f) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06.

~~(e)~~ (g) "Dentist" means an individual who is licensed to practice dentistry.

~~(f)~~ (h) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

~~(g)~~ (i) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

~~(h)~~ (j) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

~~(i)~~ (k) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.~~

~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(l)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(o)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

(r) "Public health employee" means an individual working in a local, Tribal, or state public health department.

~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(r)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(u) "Underserved patient population" means patients who are state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303.

~~(s)~~ (v) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 13. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or in underserved urban communities, or agreeing to provide at least 25 percent of the provider's yearly patient encounters to patients in an underserved patient population, or specializing in the area of pediatric psychiatry;

(2) for ~~midlevel practitioners~~ advanced practice providers agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing

field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; a school district or charter school; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, acupuncture practitioners, and public health nurses who agree to practice in designated rural areas; ~~and~~

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to ~~state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.~~ patients in an underserved patient population;

(7) for mental health professionals agreeing to provide up to 768 hours per year of clinical supervision in their designated field; and

(8) for public health employees serving in a local, Tribal, or state public health department in an area of high need as determined by the commissioner.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 14. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health employee, public health nurse, ~~midlevel practitioner~~ advanced practice provider, acupuncture practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health.

(b) Except as provided in paragraph (c), an applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

(c) An applicant selected to participate who is a public health employee is eligible for loan forgiveness within three years after completion of required training. An applicant selected to participate who is a nurse and who agrees to teach according to subdivision 2, paragraph (a), clause (3), must sign a contract to agree to teach for a minimum of two years.

Sec. 15. Minnesota Statutes 2020, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. For public health employees, available funds are limited to the appropriations funded in fiscal year 2022. In considering applications from applicants who are mental health professionals, the commissioner shall give preference to applicants who work in rural or culturally specific organizations. In considering applications from all other applicants, the commissioner shall give preference to applicants who document diverse cultural competencies. Except as provided in paragraph (b), the commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching

area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities, physicians agreeing to provide at least 25 percent of the physician's yearly patient encounters to patients in an underserved patient population, and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. Except as specified in paragraph (c), for each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

(b) The commissioner shall distribute available funds for loan forgiveness for public health employees according to areas of high need as determined by the commissioner.

(c) For each year that a participant who is a nurse and who has agreed to teach according to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average annual educational debt for indebted graduates in the nursing profession in the year

closest to the participant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans.

Sec. 16. Minnesota Statutes 2020, section 144.1503, is amended to read:

144.1503 HOME AND COMMUNITY-BASED SERVICES EMPLOYEE SCHOLARSHIP AND LOAN FORGIVENESS PROGRAM.

Subdivision 1. **Creation.** The home and community-based services employee scholarship and loan forgiveness grant program is established ~~for the purpose of assisting~~ to assist qualified provider applicants ~~to fund~~ in funding employee scholarships and qualified educational loan repayments for education, training, field experience, and examinations in nursing ~~and~~, other health care fields, and licensure as an assisted living director under section 144A.20, subdivision 4.

Subd. 1a. **Definition.** For purposes of this section, "qualified educational loan" means a government, commercial, or foundation loan secured by an employee of a qualifying provider for actual costs paid for tuition, training, and examinations; reasonable education, training, and field experience expenses; and reasonable living expenses related to the employee's graduate or undergraduate education.

Subd. 2. **Provision of grants.** The commissioner shall make grants available to qualified providers of older adult services. Grants must be used by home and community-based service providers to recruit and train staff through the establishment of an employee scholarship and loan forgiveness fund.

Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals who are 65 years of age and older in home and community-based settings, including housing with services establishments as defined in section 144D.01, subdivision 4; assisted living facilities as defined in section 144G.08, subdivision 7; adult day care as defined in section 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision 3.

(b) Qualifying providers must establish a home and community-based services employee scholarship and loan forgiveness program, as specified in subdivision 4. Providers that receive funding under this section must use the funds to award scholarships to, and to repay qualified educational loans of, employees who work an average of at least 16 hours per week for the provider.

Subd. 4. **Home and community-based services employee scholarship and loan forgiveness program.** Each qualifying provider under this section must propose a home

and community-based services employee scholarship and loan forgiveness program. Providers must establish criteria by which funds are to be distributed among employees. At a minimum, the scholarship and loan forgiveness program must cover employee costs and repay qualified educational loans of employees related to a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, ~~or~~ nursing, or management as a licensed assisted living director.

Subd. 5. **Participating providers.** The commissioner shall publish a request for proposals in the State Register, specifying provider eligibility requirements, criteria for a qualifying employee scholarship and loan forgiveness program, provider selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an application to the commissioner. Applications must contain a complete description of the employee scholarship and loan forgiveness program being proposed by the applicant, including the need for the organization to enhance the education of its workforce, the process for determining which employees will be eligible for scholarships or loan repayment, any other sources of funding for scholarships or loan repayment, the expected degrees or credentials eligible for scholarships or loan repayment, the amount of funding sought for the scholarship and loan forgiveness program, a proposed budget detailing how funds will be spent, and plans for retaining eligible employees after completion of their scholarship or repayment of their loan.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and make grant selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship and loan forgiveness selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires.

Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report shall include the amount spent on scholarships and loan repayment; the number of employees who received scholarships and the number of employees for whom loans were repaid; and, for each scholarship or loan forgiveness recipient, the name of the recipient, the current position of

the recipient, the amount awarded or loan amount repaid, the educational institution attended, the nature of the educational program, and the expected or actual program completion date. During the grant period, the commissioner may require and collect from grant recipients other information necessary to evaluate the program.

Sec. 17. **[144.1504] HOSPITAL NURSING LOAN FORGIVENESS PROGRAM.**

Subdivision 1. **Definition.** (a) For purposes of this section, the following definitions apply.

(b) "Nurse" means an individual who is licensed as a registered nurse and who is providing direct patient care in a nonprofit hospital.

(c) "PSLF program" means the federal Public Student Loan Forgiveness program established under Code of Federal Regulations, title 34, section 685.21.

Subd. 2. **Eligibility.** (a) To be eligible to participate in the hospital nursing loan forgiveness program, a nurse must be:

(1) enrolled in the PSLF program;

(2) employed full time as a registered nurse by a nonprofit hospital that is an eligible employer under the PSLF program; and

(3) providing direct care to patients at the nonprofit hospital.

(b) An applicant for loan forgiveness must submit to the commissioner of health:

(1) a completed application on forms provided by the commissioner;

(2) proof that the applicant is enrolled in the PSLF program; and

(3) confirmation that the applicant is employed full time as a registered nurse by a nonprofit hospital and is providing direct patient care.

(c) The applicant selected to participate must sign a contract to agree to continue to provide direct patient care as a registered nurse at a nonprofit hospital for the repayment period of the participant's eligible loan under the PSLF program.

Subd. 3. **Loan forgiveness.** (a) The commissioner of health shall select applicants each year for participation in the hospital nursing loan forgiveness program, within limits of available funding. Applicants are responsible for applying for and maintaining eligibility for the PSLF program.

(b) For each year that a participant meets the eligibility requirements described in subdivision 2, the commissioner shall make an annual disbursement directly to the participant

in an amount equal to the minimum loan payments required to be paid by the participant under the participant's repayment plan under the PSLF program for the previous loan year. Before receiving the annual loan repayment disbursement, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner, verifying that the participant continues to meet the eligibility requirements under subdivision 2.

(c) The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the loan for which forgiveness is sought under the PSLF program.

Subd. 4. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service as required under subdivision 2, or the secretary of education determines that the participant does not meet eligibility requirements for the PSLF program, the commissioner shall collect from the participant the total amount paid to the participant under the hospital nursing loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in section 144.1501, subdivision 2. The commissioner shall allow waivers of all or part of the money owed to the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevent fulfillment of the service commitment or if the PSLF program is discontinued before the participant's service commitment is fulfilled.

Sec. 18. Minnesota Statutes 2020, section 144.1505, is amended to read:

144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT ~~PROGRAM~~ PROGRAMS.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation;

(2) "eligible dental program" means a dental residency training program that is located in Minnesota and is currently accredited by the accrediting body or is a candidate for accreditation;

~~(2)~~ (3) "eligible dental therapy program" means a dental therapy education program or advanced dental therapy education program that is located in Minnesota and is either:

(i) approved by the Board of Dentistry; or

(ii) currently accredited by the Commission on Dental Accreditation;

~~(3)~~ (4) "eligible mental health professional program" means a program that is located in Minnesota and is listed as a mental health professional program by the appropriate accrediting body for clinical social work, psychology, marriage and family therapy, or licensed professional clinical counseling, or is a candidate for accreditation;

~~(4)~~ (5) "eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education;

~~(5)~~ (6) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation;

(7) "eligible physician program" means a physician residency training program that is located in Minnesota and is currently accredited by the accrediting body or is a candidate for accreditation;

~~(6)~~ (8) "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under section 245.462, subdivision 18; and

~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician assistants, advanced practice registered nurses, pharmacists, physicians, dentists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota.

Subd. 2. **Health professionals clinical training expansion grant program.** (a) The commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

(1) establishing or expanding clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 2a. **Health professional rural and underserved clinical rotations grant program.** (a) The commissioner of health shall award health professional training site grants to eligible physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry, dental therapy, and mental health professional programs to augment existing clinical training programs by adding rural and underserved rotations or clinical training experiences, such as credential or certificate rural tracks or other specialized training. For physician and dentist training, the expanded training must include rotations in primary care settings such as community clinics, hospitals, health maintenance organizations, or practices in rural communities.

(b) Funds may be used for:

(1) establishing or expanding rotations and clinical trainings;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand training programs; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, ~~and~~ mental health professional, physician, and dental programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization. Applicants applying under subdivision 2a must also include information about the length of training and training site settings, the geographic locations of rural sites, and rural populations expected to be served.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application and rural locations if applicable under subdivision 2b, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period,

the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 19. **[144.1507] PRIMARY CARE RURAL RESIDENCY TRAINING GRANT PROGRAM.**

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

(b) "Eligible program" means a program that meets the following criteria:

(1) is located in Minnesota;

(2) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

(3) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation.

(c) "Rural residency training program" means a residency program that utilizes local clinics and community hospitals and that provides an initial year of training in an existing accredited residency program in Minnesota. The subsequent years of the residency program are based in rural communities with specialty rotations in nearby regional medical centers.

(d) "Eligible project" means a project to establish and maintain a rural residency training program.

Subd. 2. **Rural residency training program.** (a) The commissioner of health shall award rural residency training program grants to eligible programs to plan and implement rural residency training programs. A rural residency training program grant shall not exceed $250,000 per resident per year for the first year of planning and development, and $225,000 for each of the following years.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited rural residency training program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits rural residency training programs;

(3) establishing new rural residency training programs;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new rural residency training program;

(7) training site improvements, fees, equipment, and supplies required for new rural residency training program; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications for rural residency training program grants.** (a) Eligible programs seeking a grant shall apply to the commissioner. Applications must include: (1) the number of new primary care rural residency training program slots planned, under development, or under contract; (2) a description of the training program, including the location of the established residency program and rural training sites; (3) a description of the project, including all costs associated with the project; (4) all sources of funds for the project; (5) detailed uses of all funds for the project; (6) the results expected; and (7) a plan to seek federal funding for graduate medical education for the site if eligible.

(b) The applicant must describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of grant applications.** The commissioner shall review each application to determine if the residency program application is complete, if the proposed rural residency program and residency slots are eligible for a grant, and if the program is eligible for federal graduate medical education funding, and when funding becomes available. The commissioner shall award grants to support training programs in family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, and general surgery.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

Sec. 20. **[144.1508] MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.**

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** The commissioner of health shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 3 to fund supervision of interns and clinical trainees who are working toward becoming a licensed mental health professional and to subsidize the costs of mental health professional licensing applications and examination fees for clinical trainees.

Subd. 3. **Eligible providers.** In order to be eligible for a grant under this section, a mental health provider must:

(1) provide at least 50 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve persons from communities of color or underrepresented communities.

Subd. 4. **Application; grant award.** A mental health provider seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the mental health provider is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 5. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;

(2) to establish a program to provide supervision to multiple interns or clinical trainees; or

(3) to pay mental health professional licensing application and examination fees for clinical trainees.

Subd. 6. **Program oversight.** During the grant period, the commissioner may require grant recipients to provide the commissioner with information necessary to evaluate the program.

Sec. 21. **[144.1509] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM.**

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** A mental health professional scholarship program is established to assist mental health providers in funding employee scholarships for master's level education programs in order to create a pathway to becoming a mental health professional.

Subd. 3. **Provision of grants.** The commissioner of health shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 4 to provide tuition reimbursement for master's level programs and certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the following roles:

(1) a mental health behavioral aide who meets a qualification in section 245I.04, subdivision 16;

(2) a mental health certified family peer specialist who meets the qualifications in section 245I.04, subdivision 12;

(3) a mental health certified peer specialist who meets the qualifications in section 245I.04, subdivision 10;

(4) a mental health practitioner who meets a qualification in section 245I.04, subdivision 4;

(5) a mental health rehabilitation worker who meets the qualifications in section 245I.04, subdivision 14;

(6) an individual employed in a role in which the individual provides face-to-face client services at a mental health center or certified community behavioral health center; or

(7) a staff person who provides care or services to residents of a residential treatment facility.

Subd. 4. **Eligibility.** In order to be eligible for a grant under this section, a mental health provider must:

(1) primarily provide at least 50 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve people from communities of color or underrepresented communities.

Subd. 5. **Request for proposals.** The commissioner must publish a request for proposals in the State Register specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, the maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** An eligible provider seeking a grant under this section must submit an application to the commissioner. An application must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the mental health provider to enhance the education of its workforce, the process the mental health provider will use to determine which employees will be eligible for scholarships, any other funding sources for scholarships, the amount of funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans to retain eligible employees after completion of the education program.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award amount for grants and shall select grant recipients based on the information provided in the grant application, including the demonstrated need for the applicant provider to enhance the education of its workforce, the proposed process to select employees for scholarships, the applicant's proposed budget, and other criteria as determined by the commissioner. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations.

Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, funds awarded to a grant recipient in a grant agreement do not lapse until the grant agreement expires.

Subd. 9. **Allowable uses of grant funds.** A mental health provider receiving a grant under this section must use the grant funds for one or more of the following:

(1) to provide employees with tuition reimbursement for a master's level program in a discipline that will allow the employee to qualify as a mental health professional; or

(2) for resources and supports, such as child care and transportation, that allow an employee to attend a master's level program specified in clause (1).

Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under this section shall submit to the commissioner an invoice for reimbursement and a report, on a schedule determined by the commissioner and using a form supplied by the commissioner. The report must include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the recipient's name, current position, amount awarded, educational institution attended, name of the educational program, and expected or actual program completion date.

Sec. 22. **[144.1511] CLINICAL HEALTH CARE TRAINING.**

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

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body that reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

(c) "Commissioner" means the commissioner of health.

(d) "Clinical medical education program" means the accredited clinical training of physicians, medical students and residents, doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses, clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, community health workers, and other medical professions as determined by the commissioner.

(e) "Eligible entity" means an organization that is located in Minnesota, provides a clinical medical education experience, and hosts students, residents or other trainee types as determined by the commissioner and are from an accredited Minnesota teaching program and institution.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(g) "Trainee" means a student, resident, fellow, or other postgraduate involved in a clinical medical education program from an accredited Minnesota teaching program and institution.

(h) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are training in Minnesota at an entity with either currently active medical assistance enrollment status and a National Provider Identification (NPI) number or documentation that they provide sliding fee services. Training may occur in an inpatient or ambulatory patient care setting or alternative setting as determined by the commissioner. Training that occurs in nursing facility settings is not eligible for funding under this section.

Subd. 2. **Application process.** (a) An eligible entity hosting clinical trainees from a clinical medical education program and teaching institution is eligible for funds under subdivision 3 if the entity:

(1) is funded in part by sliding fee scale services or enrolled in the Minnesota health care program;

(2) faces increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in rural or underserved areas of Minnesota.

(b) An entity hosting a clinical medical education program for advanced practice nursing is eligible for funds under subdivision 3 if the program meets the eligibility requirements in paragraph (a) and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota State Colleges and Universities system or a member of the Minnesota Private College Council.

(c) An application must be submitted to the commissioner by an eligible entity or teaching institution and contain the following information:

(1) the official name and address and the site address of the clinical medical education program where eligible trainees are hosted;

(2) the name, title, and business address of those persons responsible for administering the funds; and

(3) for each applicant: (i) the type and specialty orientation of trainees in the program; (ii) the name, entity address, and medical assistance provider number and national provider identification number of each training site used in the program, as appropriate; (iii) the federal tax identification number of each training site, where available; (iv) the total number of trainees at each training site; (v) the total number of eligible trainee FTEs at each site; and (vi) other supporting information the commissioner deems necessary.

(d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 3. **Distribution of funds.** (a) The commissioner may distribute funds for clinical training in areas of Minnesota and for professions listed in subdivision 1, paragraph (d) determined by the commissioner as a high need area and profession shortage. The commissioner shall annually distribute medical education funds to qualifying applicants under this section based on costs to train, service level needs, and profession or training site shortages. Use of funds is limited to related clinical training costs for eligible programs.

(b) To ensure the quality of clinical training, eligible entities must demonstrate that they hold contracts in good standing with eligible educational institutions that specify the terms, expectations, and outcomes of the clinical training conducted at sites. Funds shall be distributed in an administrative process determined by the commissioner to be efficient.

Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible entity. If the teaching institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) Teaching institutions receiving funds under this section must provide any other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

Sec. 23. **[144.2182] CHANGE OF SEX.**

Subdivision 1. **Request to make change.** A person whose birth is registered in Minnesota may request that the commissioner change or remove the sex, if any, assigned to that person

on the person's original birth certificate. If the person is a minor, a parent or guardian may make the request on behalf of the minor.

Subd. 2. **Documentation required.** A person making a request under this section must submit any forms or fees required by the commissioner and provide acceptable documentation to satisfy to the commissioner that granting the request will not harm the integrity and accuracy of vital records. Acceptable documentation includes but is not limited to:

(1) a written statement from a provider of medical services that the requested change is appropriate in their medical opinion;

(2) a certified copy of a court order from a court of competent jurisdiction in this or another state granting the requested change; or

(3) a sworn statement provided by the person who is the subject of the birth certificate, or by the parent or guardian of the minor who is the subject of the birth certificate, that the request is not based upon an intent to defraud or mislead and is made in good faith and, if the subject is a minor, that the change is in the minor's best interest.

Subd. 3. **Court orders.** A person may file a petition in district court to change or remove the sex assigned on their original birth certificate. If the person is a minor, a parent or guardian may file a petition on behalf of the minor. The court shall consider petitions filed by persons over whom the court has jurisdiction for an order granting a change of sex on an original birth certificate irrespective of the jurisdiction in which the original birth certificate was issued. The court shall issue an order under this section upon a finding that the request is not based upon an intent to defraud or mislead and is made in good faith and, if the subject of the birth certificate is a minor, that the change is in the minor's best interest.

Subd. 4. **Records sealed.** When the commissioner has received the necessary information and made the requested change on the birth certificate, the commissioner shall provide a certified copy of the corrected birth certificate to the person requesting the change. Upon issuance of a corrected birth certificate under this section, the original record of birth shall be classified as confidential data pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252.

Sec. 24. Minnesota Statutes 2020, section 144.383, is amended to read:

144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.

In order to ~~insure~~ ensure safe drinking water in all public water supplies, the commissioner has the ~~following powers~~ power to:

~~(a) To~~ (1) approve the site, design, and construction and alteration of all public water supplies and, for community and nontransient noncommunity water systems as defined in Code of Federal Regulations, title 40, section 141.2, to approve documentation that demonstrates the technical, managerial, and financial capacity of those systems to comply with rules adopted under this section;

~~(b) To~~ (2) enter the premises of a public water supply, or part thereof, to inspect the facilities and records kept pursuant to rules promulgated by the commissioner, to conduct sanitary surveys and investigate the standard of operation and service delivered by public water supplies;

~~(c) To~~ (3) contract with community health boards as defined in section 145A.02, subdivision 5, for routine surveys, inspections, and testing of public water supply quality;

~~(d) To~~ (4) develop an emergency plan to protect the public when a decline in water quality or quantity creates a serious health risk, and to issue emergency orders if a health risk is imminent;

~~(e) To~~ (5) promulgate rules, pursuant to chapter 14 but no less stringent than federal regulation, which may include the granting of variances and exemptions~~.~~; and

(6) maintain a database of lead service lines, provide technical assistance to community systems, and ensure the lead service inventory data is accessible to the public with relevant educational materials about health risks related to lead and ways to reduce exposure.

Sec. 25. Minnesota Statutes 2020, section 144.554, is amended to read:

144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.

For hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

Construction project total estimated cost	Fee
$0 - $10,000	~~$30~~ $45

$10,001 - $50,000	~~$150~~ $225
$50,001 - $100,000	~~$300~~ $450
$100,001 - $150,000	~~$450~~ $675
$150,001 - $200,000	~~$600~~ $900
$200,001 - $250,000	~~$750~~ $1,125
$250,001 - $300,000	~~$900~~ $1,350
$300,001 - $350,000	~~$1,050~~ $1,575
$350,001 - $400,000	~~$1,200~~ $1,800
$400,001 - $450,000	~~$1,350~~ $2,025
$450,001 - $500,000	~~$1,500~~ $2,250
$500,001 - $550,000	~~$1,650~~ $2,475
$550,001 - $600,000	~~$1,800~~ $2,700
$600,001 - $650,000	~~$1,950~~ $2,925
$650,001 - $700,000	~~$2,100~~ $3,150
$700,001 - $750,000	~~$2,250~~ $3,375
$750,001 - $800,000	~~$2,400~~ $3,600
$800,001 - $850,000	~~$2,550~~ $3,825
$850,001 - $900,000	~~$2,700~~ $4,050
$900,001 - $950,000	~~$2,850~~ $4,275
$950,001 - $1,000,000	~~$3,000~~ $4,500
$1,000,001 - $1,050,000	~~$3,150~~ $4,725
$1,050,001 - $1,100,000	~~$3,300~~ $4,950
$1,100,001 - $1,150,000	~~$3,450~~ $5,175
$1,150,001 - $1,200,000	~~$3,600~~ $5,400
$1,200,001 - $1,250,000	~~$3,750~~ $5,625
$1,250,001 - $1,300,000	~~$3,900~~ $5,850
$1,300,001 - $1,350,000	~~$4,050~~ $6,075
$1,350,001 - $1,400,000	~~$4,200~~ $6,300
$1,400,001 - $1,450,000	~~$4,350~~ $6,525
$1,450,001 - $1,500,000	~~$4,500~~ $6,750
$1,500,001 and over	~~$4,800~~ $7,200

Sec. 26. **[144.7051] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7059, the terms defined in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Daily staffing schedule.** "Daily staffing schedule" means the actual number of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and providing care in that unit during a 24-hour period and the actual number of patients assigned to each direct care registered nurse present and providing care in the unit.

Subd. 4. **Direct care registered nurse.** "Direct care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and who directly provides nursing care to patients more than 60 percent of the time.

Subd. 5. **Hospital.** "Hospital" means any setting that is licensed as a hospital under sections 144.50 to 144.56.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 27. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEES.**

Subdivision 1. **Hospital nurse staffing committee required.** Each hospital must establish and maintain a functioning hospital nurse staffing committee. A hospital may assign the functions and duties of a hospital nurse staffing committee to an existing committee, provided the existing committee meets the membership requirements applicable to a hospital nurse staffing committee.

Subd. 2. **Committee membership.** (a) At least 35 percent of the committee's membership must be direct care registered nurses typically assigned to a specific unit for an entire shift, and at least 15 percent of the committee's membership must be other direct care workers typically assigned to a specific unit for an entire shift. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses employed by the hospital, and other direct care workers shall be elected to the committee by other direct care workers employed by the hospital.

(b) The hospital shall appoint no more than 50 percent of the committee's membership.

Subd. 3. **Compensation.** A hospital must treat participation in committee meetings by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A hospital must relieve all direct care registered nurse members of the hospital nurse staffing committee of other work duties during the times at which the committee meets.

Subd. 4. **Meeting frequency.** Each hospital nurse staffing committee must meet at least quarterly.

Subd. 5. **Committee duties.** (a) Each hospital nurse staffing committee shall create, implement, continuously evaluate, and update as needed evidence-based written core staffing plans to guide the creation of daily staffing schedules for each inpatient care unit of the hospital.

(b) Each hospital nurse staffing committee must:

(1) establish a secure and anonymous method for any hospital employee or patient to submit directly to the committee any concerns related to safe staffing;

(2) review each concern related to safe staffing submitted directly to the committee;

(3) review the documentation of compliance maintained by the hospital under section 144.7056, subdivision 5;

(4) conduct a trend analysis of the data related to all reported concerns regarding safe staffing;

(5) develop a mechanism for tracking and analyzing staffing trends within the hospital;

(6) submit to the commissioner a nurse staffing report; and

(7) record in the committee minutes for each meeting a summary of the discussions and recommendations of the committee. Each committee must maintain the minutes, records, and distributed materials for five years.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 28. Minnesota Statutes 2020, section 144.7055, is amended to read:

144.7055 HOSPITAL CORE STAFFING PLAN ~~REPORTS~~.

Subdivision 1. **Definitions.** ~~(a) For the purposes of this section, the following terms have the meanings given.~~

~~(b)~~ (a) "Core staffing plan" means ~~the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~ a plan described in subdivision 2.

~~(c)~~ (b) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and other health care workers, which may include but is not limited to nursing assistants, nursing aides, patient care technicians, and patient care assistants, who perform

nonmanagerial direct patient care functions for more than 50 percent of their scheduled hours on a given patient care unit.

~~(d)~~ (c) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

~~(e)~~ (d) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.~~

Subd. 2. **Hospital core staffing ~~report~~ plans.** (a) The ~~chief nursing executive or nursing designee~~ hospital nurse staffing committee of every ~~reporting~~ hospital ~~in Minnesota under section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

(b) Core staffing plans ~~shall~~ must specify all of the following:

(1) the projected number of full-time equivalent ~~for~~ nonmanagerial care staff that will be assigned in a 24-hour period to each ~~patient~~ inpatient care unit ~~for each 24-hour period.~~;

(2) the maximum number of patients on each inpatient care unit for whom a direct care registered nurse can be assigned and for whom a licensed practical nurse or certified nursing assistant can typically safely care;

(3) criteria for determining when circumstances exist on each inpatient care unit such that a direct care nurse cannot safely care for the typical number of patients and when assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

(4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing levels when such adjustments are required by patient acuity and nursing intensity in the unit;

(5) a contingency plan for each inpatient unit to safely address circumstances in which patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing schedule. A contingency plan must include a method to quickly identify for each daily staffing schedule additional direct care registered nurses who are available to provide direct care on the inpatient care unit; and

(6) strategies to enable direct care registered nurses to take breaks to which they are entitled under law or under an applicable collective bargaining agreement.

(c) Core staffing plans must ensure that:

(1) the person creating a daily staffing schedule has sufficiently detailed information to create a daily staffing schedule that meets the requirements of the plan;

(2) daily staffing nurse schedules do not rely on assigning individual nonmanagerial care staff to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive 24-hour periods requiring 16 or more hours;

(3) a direct care registered nurse is not required or expected to perform functions outside the nurse's professional license;

(4) light duty direct care registered nurses are given appropriate assignments; and

(5) daily staffing schedules do not interfere with applicable collective bargaining agreements.

Subd. 2a. **Development of hospital core staffing plans.** (a) Prior to ~~submitting~~ completing or updating the core staffing plan, ~~as required in subdivision 3, hospitals shall~~ a hospital nurse staffing committee must consult with representatives of the hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan and the expected average number of patients upon which the core staffing plan is based.

(b) When developing a core staffing plan, a hospital nurse staffing committee must consider all of the following:

(1) the individual needs and expected census of each inpatient care unit;

(2) unit-specific patient acuity, including fall risk and behaviors requiring intervention, such as physical aggression toward self or others, or destruction of property;

(3) unit-specific demands on direct care registered nurses' time, including: frequency of admissions, discharges, and transfers; frequency and complexity of patient evaluations and assessments; frequency and complexity of nursing care planning; planning for patient discharge; assessing for patient referral; patient education; and implementing infectious disease protocols;

(4) the architecture and geography of the inpatient care unit, including the placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

(5) mechanisms and procedures to provide for one-to-one patient observation for patients on psychiatric or other units;

(6) the stress under which direct care nurses are placed when required to work extreme amounts of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

(7) the need for specialized equipment and technology on the unit;

(8) other special characteristics of the unit or community patient population, including age, cultural and linguistic diversity and needs, functional ability, communication skills, and other relevant social and socioeconomic factors;

(9) the skill mix of personnel other than direct care registered nurses providing or supporting direct patient care on the unit;

(10) mechanisms and procedures for identifying additional registered nurses who are available for direct patient care when patients' unexpected needs exceed the planned workload for direct care staff; and

(11) demands on direct care registered nurses' time not directly related to providing direct care on a unit, such as involvement in quality improvement activities, professional development, service to the hospital, including serving on the hospital nurse staffing committee, and service to the profession.

Subd. 3. **Standard electronic reporting ~~developed~~ of core staffing plans.** ~~(a) Hospitals~~ Each hospital must submit the core staffing plans approved by the hospital's nurse staffing committee to the Minnesota Hospital Association ~~by January 1, 2014~~. The Minnesota Hospital Association shall include each ~~reporting~~ hospital's core staffing ~~plan~~ plans on the Minnesota Hospital Association's Minnesota Hospital Quality Report website ~~by April 1, 2014~~ by June 1, 2024. Hospitals shall submit to the Minnesota Hospital Association any substantial ~~changes~~ updates to ~~the~~ a core staffing plan ~~shall be updated~~ within 30 days of the approval of the updates by the hospital's nurse staffing committee or of amendment through arbitration. The Minnesota Hospital Association shall update the Minnesota Hospital Quality Report website with the updated core staffing plans within 30 days of receipt of the updated plan.

Subd. 4. **Standard electronic reporting of direct patient care report.** ~~(b)~~ The Minnesota Hospital Association shall include on its website for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit. Hospitals must submit the

direct patient care report to the Minnesota Hospital Association ~~by July 1, 2014, and~~ quarterly ~~thereafter~~.

Subd. 5. **Mandatory submission of core staffing plan to commissioner.** Each hospital must submit the core staffing plans and any updates to the commissioner on the same schedule described in subdivision 3. Core staffing plans held by the commissioner are public.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 29. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

Subdivision 1. **Plan implementation required.** A hospital must implement the core staffing plans approved by a majority vote of the hospital nurse staffing committee.

Subd. 2. **Public posting of core staffing plans.** A hospital must post the core staffing plan for the inpatient care unit in a public area on the unit.

Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing plan, a hospital must post a notice stating whether the current staffing on the unit complies with the hospital's core staffing plan for that unit. The public notice of compliance must include a list of the number of nonmanagerial care staff working on the unit during the current shift and the number of patients assigned to each direct care registered nurse working on the unit during the current shift. The list must enumerate the nonmanagerial care staff by health care worker type. The public notice of compliance must be posted immediately adjacent to the publicly posted core staffing plan.

Subd. 4. **Public distribution of core staffing plan and notice of compliance.** (a) A hospital must include with the posted materials described in subdivisions 2 and 3, a statement that individual copies of the posted materials are available upon request to any patient on the unit or to any visitor of a patient on the unit. The statement must include specific instructions for obtaining copies of the posted materials.

(b) A hospital must, within four hours after the request, provide individual copies of all the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any visitor of a patient on the unit who requests the materials.

Subd. 5. **Documentation of compliance.** Each hospital must document compliance with its core nursing plans and maintain records demonstrating compliance for each inpatient care unit for five years. Each hospital must provide its nurse staffing committee with access to all documentation required under this subdivision.

Subd. 6. **Dispute resolution.** (a) If hospital management objects to a core staffing plan approved by a majority vote of the hospital nurse staffing committee, the hospital may elect to attempt to amend the core staffing plan through arbitration.

(b) During an ongoing dispute resolution process, a hospital must continue to implement the core staffing plan as written and approved by the hospital nurse staffing committee.

(c) If the dispute resolution process results in an amendment to the core staffing plan, the hospital must implement the amended core staffing plan.

EFFECTIVE DATE. This section is effective June 1, 2024.

Sec. 30. **[144.7059] RETALIATION PROHIBITED.**

Neither a hospital or nor a health-related licensing board may retaliate against or discipline a hospital employee regulated by the health-related licensing board, either formally or informally, for:

(1) challenging the process by which a hospital nurse staffing committee is formed or conducts its business;

(2) challenging a core staffing plan approved by a hospital nurse staffing committee;

(3) objecting to or submitting a grievance related to a patient assignment that leads to a direct care registered nurse violating medical restrictions recommended by the nurse's medical provider; or

(4) submitting a report of unsafe staffing conditions.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 31. **[144.8611] DRUG OVERDOSE AND SUBSTANCE ABUSE PREVENTION.**

Subdivision 1. **Strategies.** The commissioner of health shall support collaboration and coordination between state and community partners to develop, refine, and expand comprehensive funding to address the drug overdose epidemic by implementing three strategies: (1) regional multidisciplinary overdose prevention teams to implement overdose prevention in local communities and local public health organizations; (2) enhance supportive services for the homeless who are at risk of overdose by providing emergency and short-term housing subsidies through the Homeless Overdose Prevention Hub; and (3) enhance employer resources to promote health and well-being of employees through the recovery friendly workplace initiative. These strategies address the underlying social conditions that impact health status.

Subd. 2. **Regional teams.** The commissioner of health shall establish community-based prevention grants and contracts for the eight regional multidisciplinary overdose prevention teams. These teams are geographically aligned with the eight emergency medical services regions described in section 144E.52. The regional teams shall implement prevention programs, policies, and practices that are specific to the challenges and responsive to the data of the region.

Subd. 3. **Homeless Overdose Prevention Hub.** The commissioner of health shall establish a community-based grant to enhance supportive services for the homeless who are at risk of overdose by providing emergency and short-term housing subsidies through the Homeless Overdose Prevention Hub. The Homeless Overdose Prevention Hub serves primarily urban American Indians in Minneapolis and Saint Paul and is managed by the Native American Community Clinic.

Subd. 4. **Workplace health.** The commissioner of health shall establish a grants and contracts program to strengthen the recovery friendly workplace initiative. This initiative helps create work environments that promote employee health, safety, and well-being by: (1) preventing abuse and misuse of drugs in the first place; (2) providing training to employers; and (3) reducing stigma and supporting recovery for people seeking services and who are in recovery.

Subd. 5. **Eligible grantees.** (a) Organizations eligible to receive grant funding under subdivision 4 include not-for-profit agencies or organizations with existing organizational structure, capacity, trainers, facilities, and infrastructure designed to deliver model workplace policies and practices; that have training and education for employees, supervisors, and executive leadership of companies, businesses, and industry; and that have the ability to evaluate the three goals of the workplace initiative specified in subdivision 4.

(b) At least one organization may be selected for a grant under subdivision 4 with statewide reach and influence. Up to five smaller organizations may be selected to reach specific geographic or population groups.

Subd. 6. **Evaluation.** The commissioner of health shall design, conduct, and evaluate each of the components of the drug overdose and substance abuse prevention program using measures such as mortality, morbidity, homelessness, workforce wellness, employee retention, and program reach.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 32. Minnesota Statutes 2020, section 144.9501, subdivision 9, is amended to read:

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ~~ten~~ 3.5 micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

Sec. 33. **[144.9981] CLIMATE RESILIENCY.**

Subdivision 1. **Climate resiliency program.** The commissioner of health shall implement a climate resiliency program to:

(1) increase awareness of climate change;

(2) track the public health impacts of climate change and extreme weather events;

(3) provide technical assistance and tools that support climate resiliency to local public health, Tribal health, soil and water conservation districts, and other local governmental and nongovernmental organizations; and

(4) coordinate with the commissioners of the pollution control agency, natural resources, agriculture and other state agencies in climate resiliency related planning and implementation.

Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage a grant program for the purpose of climate resiliency planning. The commissioner shall award grants through a request for proposals process to local public health organizations, Tribal health organizations, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Priority shall be given to small rural water systems and organizations incorporating the needs of private water supplies into their planning. Priority shall also be given to organizations that serve communities that are disproportionately impacted by climate change.

(b) Grantees must use the funds to develop a plan or implement strategies that will reduce the risk of health impacts from extreme weather events. The grant application must include:

(1) a description of the plan or project for which the grant funds will be used;

(2) a description of the pathway between the plan or project and its impacts on health;

(3) a description of the objectives, a work plan, and a timeline for implementation; and

(4) the community or group the grant proposes to focus on.

Sec. 34. **[145.361] LONG COVID; SUPPORTING SURVIVORS AND MONITORING IMPACT.**

Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post COVID, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

Subd. 2. **Statewide monitoring.** The commissioner of health shall establish a program to conduct community needs assessments, perform epidemiologic studies, and establish a population-based surveillance system to address long COVID. The purpose of these assessments, studies, and surveillance system is to:

(1) monitor trends in incidence, prevalence, mortality, care management, health outcomes, quality of life, and needs of individuals with long COVID and to detect potential public health problems, predict risks, and assist in investigating long COVID health disparities;

(2) more accurately target intervention resources for communities and patients and their families;

(3) inform health professionals and citizens about risks, early detection, and treatment of long COVID known to be elevated in their communities; and

(4) promote high quality research to provide better information for long COVID prevention and control and to address public concerns and questions about long COVID.

Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health care professionals, the Department of Human Services, local public health organizations, health insurers, employers, schools, long COVID survivors, and community organizations serving people at high risk of long COVID, routinely identify priority actions and activities to address the need for communication, services, resources, tools, strategies, and policies to support long COVID survivors and their families.

Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions, including through community-based grants and contracts.

Subd. 5. **Grant recipient and contractor eligibility.** The commissioner of health shall award contracts and competitive grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American

Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within such groups.

Subd. 6. **Grants and contracts authorized.** The commissioner of health shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID, their caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, local and Tribal public health, and other entities deemed necessary.

Sec. 35. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 6. **988; National Suicide Prevention Lifeline number.** The National Suicide Prevention Lifeline is expanded to improve the quality of care and access to behavioral health crisis services and to further health equity and save lives.

Sec. 36. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 7. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "National Suicide Prevention Lifeline" means a national network of certified local crisis centers maintained by the Federal Substance Abuse and Mental Health Services Administration that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, seven days a week.

(c) "988 Hotline" or "Lifeline Center" means a state identified center that is a member of the National Suicide Prevention Lifeline network that responds to statewide or regional 988 contacts.

(d) "988 administrator" means the administrator of the 988 National Suicide Prevention Lifeline.

(e) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary of Veterans Affairs under United States Code, title 38, section 170F(h).

(f) "Department" means the Department of Health.

(g) "Commissioner" means the commissioner of health.

Sec. 37. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 8. **988 National Suicide Prevention Lifeline.** (a) The commissioner of health shall administer the designated lifeline and oversee a Lifeline Center or a network of Lifeline Centers to answer contacts from individuals accessing the National Suicide Prevention Lifeline 24 hours per day, seven days per week.

(b) The designated Lifeline Center(s) shall:

(1) have an active agreement with the administrator of the 988 National Suicide Prevention Lifeline for participation within the network;

(2) meet the 988 administrator requirements and best practice guidelines for operational and clinical standards;

(3) provide data, report, and participate in evaluations and related quality improvement activities as required by the 988 administrator and the department;

(4) use technology that is interoperable across crisis and emergency response systems used in the state, such as 911 systems, emergency medical services, and the National Suicide Prevention Lifeline;

(5) deploy crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 administrator and the department;

(6) actively collaborate with local mobile crisis teams to coordinate linkages for persons contacting the 988 Hotline for ongoing care needs;

(7) offer follow-up services to individuals accessing the Lifeline Center that are consistent with guidance established by the 988 administrator and the department; and

(8) meet the requirements set by the 988 administrator and the department for serving high risk and specialized populations.

(c) The department shall collaborate with the National Suicide Prevention Lifeline and Veterans Crisis Line networks for the purpose of ensuring consistency of public messaging about 988 services.

Sec. 38. **[145.871] UNIVERSAL, VOLUNTARY HOME VISITING PROGRAM.**

Subdivision 1. **Grant program.** (a) The commissioner of health shall award grants to eligible individuals and entities to establish voluntary home visiting services to families expecting or caring for an infant, including families adopting an infant. The following

individuals and entities are eligible for a grant under this section: community health boards; nonprofit organizations; Tribal Nations; and health care providers, including doulas, community health workers, perinatal health educators, early childhood family education home visiting providers, nurses, community health technicians, and local public health nurses.

(b) The grant money awarded under this section must be used to establish home visiting services that:

(1) provide a range of one to six visits that occur prenatally or within the first four months of the expected birth or adoption of an infant; and

(2) improve outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

(iv) coordination and referral for other community resources and supports;

(v) reduction in child injuries, abuse, or neglect; or

(vi) reduction in crime or domestic violence.

(c) The commissioner shall ensure that the voluntary home visiting services established under this section are available to all families residing in the state by June 30, 2025. In awarding grants prior to the home visiting services being available statewide, the commissioner shall prioritize applicants serving high-risk or high-need populations of pregnant women and families with infants, including populations with insufficient access to prenatal care, high incidence of mental illness or substance use disorder, low socioeconomic status, and other factors as determined by the commissioner.

Subd. 2. **Home visiting services.** (a) The home visiting services provided under this section must, at a minimum:

(1) offer information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services in the community;

(2) provide information on and referrals to health care services, including information on and assistance in applying for health care coverage for which the child or family may be eligible, and provide information on the availability of group prenatal care, preventative services, developmental assessments, and public assistance programs as appropriate;

(3) include an assessment of the physical, social, and emotional factors affecting the family and provide information and referrals to address each family's identified needs;

(4) connect families to additional resources available in the community, including early care and education programs, health or mental health services, family literacy programs, employment agencies, and social services, as needed;

(5) utilize appropriate racial, ethnic, and cultural approaches to providing home visiting services; and

(6) be voluntary and free of charge to families.

(b) Home visiting services under this section may be provided through telephone or video communication when the commissioner determines the methods are necessary to protect the health and safety of individuals receiving the visits and the home visiting workforce.

Subd. 3. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance, to administer the program, and to conduct ongoing evaluations of the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Sec. 39. Minnesota Statutes 2020, section 145.924, is amended to read:

145.924 AIDS PREVENTION GRANTS.

(a) The commissioner may award grants to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, minorities, adolescents, intravenous drug users, and homosexual men.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including intravenous drug users and their partners, adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policy makers representative of the targeted population; that have experience in dealing with issues relating

to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific community.

(c) All state grants awarded under this section for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

(d) The commissioner may manage a program and award grants to agencies experienced in syringe services programs for expanding access to harm reduction services and improving linkages to care to prevent HIV/AIDS, hepatitis, and other infectious diseases for those experiencing homelessness or housing instability.

Sec. 40. **[145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the community solutions for a healthy child development grant program. The purposes of the program are to:

(1) improve child development outcomes related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Service's early childhood systems reform effort that include: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments, by funding community-based solutions for challenges that are identified by the affected communities;

(2) reduce racial disparities in children's health and development from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the community solutions advisory council established in subdivision 3;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the community solutions advisory council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the Children's Cabinet on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the community solutions advisory council, focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community solutions advisory council; establishment; duties; compensation.** (a) The commissioner of health shall establish a community solutions advisory council. By October 1, 2022, the commissioner shall convene a 12-member community solutions advisory council. Members of the advisory council are:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents who are Black, indigenous, or nonwhite people of color with children under nine years of age;

(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians.

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

(c) The community solutions advisory council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the

council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(d) Each advisory council member shall be compensated as provided in section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with Black, indigenous, and non-Black people of color communities;

(2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the community solutions advisory council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of Black, nonwhite people of color, and American Indian communities from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by Black and other nonwhite people of color and serving Black and nonwhite communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including Tribal nations and Tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

(c) The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(d) The first round of grants must be awarded no later than April 15, 2023.

Subd. 6. **Geographic distribution of grants.** To the extent possible, the commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black, nonwhite people of color, and American Indians than the state average.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 41. **[145.9272] LEAD REMEDIATION IN SCHOOLS AND CHILD CARE SETTINGS GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of remediating identified sources of lead in drinking water in schools and child care settings.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to schools and child care settings. Priority shall be given to schools and child care settings with: (1) higher levels of lead detected in water samples; (2) evidence of lead service lines or lead plumbing materials; and (3) school districts that serve disadvantaged communities.

Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead contamination in their facilities including but not limited to service connections, premise plumbing, and implementing best practices for water management within the building.

Sec. 42. **[145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Grant program.** The commissioner of health shall award grants through a request for proposal process to community-based organizations that serve ethnic communities and focus on public health outreach to Black and people of color communities on the issues of colorism, skin-lightening products, and chemical exposures from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin-lightening and chemical exposure issue for the past four years.

Subd. 2. **Uses of grant funds.** Grant recipients must use grant funds awarded under this section to conduct public awareness and education activities that are culturally specific and community-based and that focus on:

(1) increasing public awareness and providing education on the health dangers associated with using skin-lightening creams and products that contain mercury and hydroquinone and are manufactured in other countries, brought into this country, and sold illegally online or in stores; the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and contact with individuals who have used these skin-lightening products; the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys; and the dangers to mothers and infants of using these products or being exposed to these products during pregnancy and while breastfeeding;

(2) identifying products that contain mercury and hydroquinone by testing skin-lightening products;

(3) developing a train the trainer curriculum to increase community knowledge and influence behavior changes by training community leaders, cultural brokers, community health workers, and educators;

(4) continuing to build the self-esteem and overall wellness of young people who are using skin-lightening products or are at risk of starting the practice of skin lightening; and

(5) building the capacity of community-based organizations to continue to combat skin-lightening practices and chemical exposure.

Sec. 43. **[145.9282] COMMUNITY HEALTH WORKERS; REDUCING HEALTH DISPARITIES WITH COMMUNITY-LED CARE.**

Subdivision 1. **Establishment.** The commissioner of health shall support collaboration and coordination between state and community partners to develop, refine, and expand the

community health workers profession across the state equipping them to address health needs and to improve health outcomes by addressing the social conditions that impact health status. Community health professionals' work expands beyond health care to bring health and racial equity into public safety, social services, youth and family services, schools, neighborhood associations, and more.

Subd. 2. **Grants authorized; eligibility.** The commissioner of health shall establish a community-based grant to expand and strengthen the community health workers workforce across the state. The grantee must be a not-for-profit community organization serving, convening, and supporting community health workers (CHW) statewide.

Subd. 3. **Evaluation.** The commissioner of health shall design, conduct, and evaluate the CHW initiative using measures of workforce capacity, employment opportunity, reach of services, and return on investment, as well as descriptive measures of the extant CHW models as they compare with the national community health workers' landscape. These more proximal measures are collected and analyzed as foundational to longer-term change in social determinants of health and rates of death and injury by suicide, overdose, firearms, alcohol, and chronic disease.

Subd. 4. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 44. **[145.9283] REDUCING HEALTH DISPARITIES AMONG PEOPLE WITH DISABILITIES; GRANTS.**

Subdivision 1. **Goal and establishment.** The commissioner of health shall support collaboration and coordination between state and community partners to address equity barriers to health care and preventative services for chronic diseases among people with disabilities. The commissioner of health, in consultation with the Olmstead Implementation Office, Department of Human Services, Board on Aging, health care professionals, local public health, and other community organizations that serve people with disabilities, shall routinely identify priorities and action steps to address identified gaps in services, resources, and tools.

Subd. 2. **Assessment and tracking.** The commissioner of health shall conduct community needs assessments and establish a health surveillance and tracking plan in collaboration with community and organizational partners to identify and address health disparities.

Subd. 3. **Grants authorized.** The commissioner of health shall establish community-based grants to support establishing inclusive evidence-based chronic disease prevention and management services to address identified gaps and disparities.

Subd. 4. **Technical assistance.** The commissioner of health shall provide and evaluate training and capacity-building technical assistance on accessible preventive health care for public health and health care providers of chronic disease prevention and management programs and services.

Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 45. **[145.9292] PUBLIC HEALTH AMERICORPS.**

The commissioner may award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program in the form and at the timelines specified by the commissioner.

Sec. 46. **[145.987] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act is to: (1) address the significant disparities in early childhood outcomes and increase the number of children who are school ready through establishing the Minnesota collaborative to prevent infant mortality; (2) sustain the Help Me Connect online navigator; (3) improve universal access to developmental and social-emotional screening and follow-up; and (4) sustain and expand the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota collaborative to prevent infant mortality.** (a) The Minnesota collaborative to prevent infant mortality is established. The goal of the Minnesota collaborative to prevent infant mortality program is to:

(1) build a statewide multisectoral partnership including the state government, local public health organizations, Tribes, the private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

(b) The commissioner of health shall establish a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

Subd. 3. **Grants authorized.** (a) The commissioner of health shall award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally relevant activities to improve infant health by reducing preterm births, sleep-related infant deaths, and congenital malformations and by addressing social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. Grants shall be awarded to all federally recognized Tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 2 and other requirements of this section. An eligible applicant must submit an application to the commissioner of health on a form designated by the commissioner and by the deadline established by the commissioner. The commissioner shall award grants to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities shall:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) be focused on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications under this subdivision, the commissioner shall establish criteria including but not limited to: (1) the eligibility of the project; (2) the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; (3) a description of the applicant's proposed project; (4) a description of the population demographics and

service area of the proposed project; and (5) evidence of efficiencies and effectiveness gained through collaborative efforts.

(d) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 4. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and to provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

(4) communications, convening, and sharing lessons learned; and

(5) health equity.

Subd. 5. **Help Me Connect.** The Help Me Connect online navigator is established. The goal of Help Me Connect is to connect pregnant and parenting families with young children from birth to eight years of age with services in their local communities that support healthy child development and family well-being. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this subdivision.

Subd. 6. **Duties of Help Me Connect.** (a) Help Me Connect shall facilitate collaboration across sectors covering child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support early detection, intervention, and knowledge about local resources; and

(2) linking children and families to appropriate community-based services.

(b) Help Me Connect shall provide community outreach that includes support for and participation in the help me connect system, including disseminating information and compiling and maintaining a current resource directory that includes but is not limited to

primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health and human services and resources, and other appropriate early childhood information.

(c) Help Me Connect shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) Help Me Connect shall provide a centralized mechanism that facilitates provider-to-provider referrals to community resources and monitors referrals to ensure that families are connected to services.

(e) Help Me Connect shall collect program evaluation data to increase the understanding of all aspects of the current and ongoing system under this section, including identification of gaps in service, barriers to finding and receiving appropriate service, and lack of resources.

Subd. 7. **Universal and voluntary developmental and social-emotional screening and follow-up.** (a) The commissioner shall establish a universal and voluntary developmental and social-emotional screening to identify young children at risk for developmental and behavioral concerns. Follow-up services shall be provided to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this subdivision and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

(b) The commissioner shall:

(1) increase the awareness of universal and voluntary developmental and social-emotional screening and follow-up in coordination with community and state partners;

(2) expand existing electronic screening systems to administer developmental and social-emotional screening of children from birth to kindergarten entrance;

(3) provide universal and voluntary periodic screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the child's parent or guardian;

(5) support families in their role as caregivers by providing typical growth and development information, anticipatory guidance, and linkages to early childhood resources and programs;

(6) ensure that children and families are linked to appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

(7) establish performance measures and collect, analyze, and share program data regarding population-level outcomes of developmental and social-emotional screening, and make referrals to community-based services and follow-up activities.

Subd. 8. **Grants authorized.** The commissioner shall award grants to community health boards and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 9. **Model jails practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties, groups of counties, or nonprofit organizations to implement model jails practices to benefit the children of incarcerated parents.

(b) "Model jail practices" means a set of practices that correctional administrators can implement to remove barriers that may prevent a child from cultivating or maintaining relationships with the child's incarcerated parent or parents during and immediately after incarceration without compromising the safety or security of the correctional facility.

Subd. 10. **Grants authorized.** (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) Grantee activities may include but are not limited to:

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

(c) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 11. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

Sec. 47. **[145.988] MINNESOTA SCHOOL HEALTH INITIATIVE.**

Subdivision 1. **Purpose.** (a) The purpose of the Minnesota School Health Initiative is to implement evidence-based practices to strengthen and expand health promotion and health care delivery activities in schools to improve the holistic health of students. To better serve students, the Minnesota School Health Initiative shall utilize the best practices of the school-based health center model.

(b) The commissioner of health and the commissioner of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, by licensed and qualified health professionals in accordance with federal, state, and local law. When not located on school property, the school-based health center must have an established

relationship with one or more schools in the community and operate primarily to serve those student groups.

(c) "Sponsoring organization" means any of the following that operate a school-based health center:

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 3. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

(1) operate in partnership with a school or district and with the permission of the school or district board;

(2) provide health services through a sponsoring organization that is specified in subdivision 2; and

(3) provide health services to all students and youth within a school or district regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

Subd. 4. **School-based health center services.** Services provided by a school-based health center may include but are not limited to:

(1) preventative health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

Subd. 5. **Sponsoring organization.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or district and must identify the costs that are the responsibility of the school or district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health center in order to maintain the financial sustainability of the school-based health center.

Subd. 6. **Technical assistance and oversight.** (a) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(b) Contracts awarded under paragraph (a) may be used to provide technical assistance and training in the areas of:

(1) needs assessment;

(2) community engagement and capacity building;

(3) community asset building and risk behavior reduction;

(4) dental provider training in calibration;

(5) dental services related equipment, instruments, supplies;

(6) communications;

(7) community, school, health care, work site, and other site-specific strategies;

(8) health equity;

(9) data collection and analysis; and

(10) evaluation.

Sec. 48. Minnesota Statutes 2020, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Services Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities shall be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. Community health boards must use these funds as specified in subdivision 5.

Sec. 49. Minnesota Statutes 2020, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds distributed according to subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) A community health board must use funding for foundational public health responsibilities that is distributed according to subdivision 1, paragraph (f), to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the State Community Health Services Advisory Committee.

(c) Notwithstanding paragraph (b), if a community health board can demonstrate that foundational public health responsibilities are fulfilled, the community health board may use funding for foundational public health responsibilities for local priorities developed through the community health assessment and community health improvement planning process.

(d) Notwithstanding paragraphs (a) to (c), by July 1, 2026, community health boards must use all local public health funds first to fulfill foundational public health responsibilities. Once a community health board can demonstrate foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 50. Minnesota Statutes 2020, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Tribal governments; foundational public health responsibilities.** The commissioner shall distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Sec. 51. Minnesota Statutes 2020, section 149A.01, subdivision 2, is amended to read:

Subd. 2. **Scope.** In Minnesota no person shall, without being licensed or registered by the commissioner of health:

(1) take charge of or remove from the place of death a dead human body;

(2) prepare a dead human body for final disposition, in any manner; or

(3) arrange, direct, or supervise a funeral, memorial service, or graveside service.

Sec. 52. Minnesota Statutes 2020, section 149A.01, subdivision 3, is amended to read:

Subd. 3. **Exceptions to licensure.** (a) Except as otherwise provided in this chapter, nothing in this chapter shall in any way interfere with the duties of:

(1) an anatomical bequest program located within an accredited school of medicine or an accredited college of mortuary science;

(2) a person engaged in the performance of duties prescribed by law relating to the conditions under which unclaimed dead human bodies are held subject to anatomical study;

(3) authorized personnel from a licensed ambulance service in the performance of their duties;

(4) licensed medical personnel in the performance of their duties; or

(5) the coroner or medical examiner in the performance of the duties of their offices.

(b) This chapter does not apply to or interfere with the recognized customs or rites of any culture or recognized religion in the ceremonial washing, dressing, casketing, and public transportation of their dead, to the extent that all other provisions of this chapter are complied with.

(c) Noncompensated persons with the right to control the dead human body, under section 149A.80, subdivision 2, may remove a body from the place of death; transport the body; prepare the body for disposition, except embalming; or arrange for final disposition of the body, provided that all actions are in compliance with this chapter.

(d) Persons serving internships pursuant to section 149A.20, subdivision 6, ~~or~~ students officially registered for a practicum or clinical through a program of mortuary science accredited by the American Board of Funeral Service Education, or transfer care specialists registered pursuant to section 149A.47 are not required to be licensed, provided that the persons or students are registered with the commissioner and act under the direct and exclusive supervision of a person holding a current license to practice mortuary science in Minnesota.

(e) Notwithstanding this subdivision, nothing in this section shall be construed to prohibit an institution or entity from establishing, implementing, or enforcing a policy that permits

only persons licensed by the commissioner to remove or cause to be removed a dead body or body part from the institution or entity.

(f) An unlicensed person may arrange for and direct or supervise a memorial service if that person or that person's employer does not have charge of the dead human body. An unlicensed person may not take charge of the dead human body, unless that person has the right to control the dead human body under section 149A.80, subdivision 2, or is that person's noncompensated designee.

Sec. 53. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 12c. **Dead human body or body.** "Dead human body" or "body" includes an identifiable human body part that is detached from a human body.

Sec. 54. Minnesota Statutes 2020, section 149A.02, subdivision 13a, is amended to read:

Subd. 13a. **Direct supervision.** "Direct supervision" means overseeing the performance of an individual. For the purpose of a clinical, practicum, ~~or~~ internship, or registration, direct supervision means that the supervisor is available to observe and correct, as needed, the performance of the trainee or registrant. The mortician supervisor is accountable for the actions of the clinical student, practicum student, ~~or~~ intern, or registrant throughout the course of the training. The supervising mortician is accountable for any violations of law or rule, in the performance of their duties, by the clinical student, practicum student, ~~or~~ intern, or registrant.

Sec. 55. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 37d. **Registrant.** "Registrant" means any person who is registered as a transfer care specialist under section 149A.47.

Sec. 56. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 37e. **Transfer care specialist.** "Transfer care specialist" means an individual who is registered with the commissioner in accordance with section 149A.47 and is authorized to perform the removal of a dead human body from the place of death under the direct supervision of a licensed mortician.

Sec. 57. Minnesota Statutes 2020, section 149A.03, is amended to read:

149A.03 DUTIES OF COMMISSIONER.

The commissioner shall:

(1) enforce all laws and adopt and enforce rules relating to the:

(i) removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies;

(ii) licensure, registration, and professional conduct of funeral directors, morticians, interns, transfer care specialists, practicum students, and clinical students;

(iii) licensing and operation of a funeral establishment;

(iv) licensing and operation of an alkaline hydrolysis facility; and

(v) licensing and operation of a crematory;

(2) provide copies of the requirements for licensure, registration, and permits to all applicants;

(3) administer examinations and issue licenses, registrations, and permits to qualified persons and other legal entities;

(4) maintain a record of the name and location of all current licensees, registrants, and interns;

(5) perform periodic compliance reviews and premise inspections of licensees;

(6) accept and investigate complaints relating to conduct governed by this chapter;

(7) maintain a record of all current preneed arrangement trust accounts;

(8) maintain a schedule of application, examination, permit, registration, and licensure fees, initial and renewal, sufficient to cover all necessary operating expenses;

(9) educate the public about the existence and content of the laws and rules for mortuary science licensing and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies to enable consumers to file complaints against licensees and others who may have violated those laws or rules;

(10) evaluate the laws, rules, and procedures regulating the practice of mortuary science in order to refine the standards for licensing and to improve the regulatory and enforcement methods used; and

(11) initiate proceedings to address and remedy deficiencies and inconsistencies in the laws, rules, or procedures governing the practice of mortuary science and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies.

Sec. 58. Minnesota Statutes 2020, section 149A.09, is amended to read:

149A.09 DENIAL; REFUSAL TO REISSUE; REVOCATION; SUSPENSION; LIMITATION OF LICENSE, REGISTRATION, OR PERMIT.

Subdivision 1. **Denial; refusal to renew; revocation; and suspension.** The regulatory agency may deny, refuse to renew, revoke, or suspend any license, registration, or permit applied for or issued pursuant to this chapter when the person subject to regulation under this chapter:

(1) does not meet or fails to maintain the minimum qualification for holding a license, registration, or permit under this chapter;

(2) submits false or misleading material information to the regulatory agency in connection with a license, registration, or permit issued by the regulatory agency or the application for a license, registration, or permit;

(3) violates any law, rule, order, stipulation agreement, settlement, compliance agreement, license, registration, or permit that regulates the removal, preparation, transportation, arrangements for disposition, or final disposition of dead human bodies in Minnesota or any other state in the United States;

(4) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt, or a no contest plea in any court in Minnesota or any other jurisdiction in the United States. "Conviction," as used in this subdivision, includes a conviction for an offense which, if committed in this state, would be deemed a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned, but the adjudication of guilt is either withheld or not entered;

(5) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt, or a no contest plea in any court in Minnesota or any other jurisdiction in the United States that the regulatory agency determines is reasonably related to the removal, preparation, transportation, arrangements for disposition or final disposition of dead human bodies, or the practice of mortuary science;

(6) is adjudicated as mentally incompetent, mentally ill, developmentally disabled, or mentally ill and dangerous to the public;

(7) has a conservator or guardian appointed;

(8) fails to comply with an order issued by the regulatory agency or fails to pay an administrative penalty imposed by the regulatory agency;

(9) owes uncontested delinquent taxes in the amount of $500 or more to the Minnesota Department of Revenue, or any other governmental agency authorized to collect taxes anywhere in the United States;

(10) is in arrears on any court ordered family or child support obligations; or

(11) engages in any conduct that, in the determination of the regulatory agency, is unprofessional as prescribed in section 149A.70, subdivision 7, or renders the person unfit to practice mortuary science or to operate a funeral establishment or crematory.

Subd. 2. **Hearings related to refusal to renew, suspension, or revocation of license, registration, or permit.** If the regulatory agency proposes to deny renewal, suspend, or revoke a license, registration, or permit issued under this chapter, the regulatory agency must first notify, in writing, the person against whom the action is proposed to be taken and provide an opportunity to request a hearing under the contested case provisions of sections 14.57 to 14.62. If the subject of the proposed action does not request a hearing by notifying the regulatory agency, by mail, within 20 calendar days after the receipt of the notice of proposed action, the regulatory agency may proceed with the action without a hearing and the action will be the final order of the regulatory agency.

Subd. 3. **Review of final order.** A judicial review of the final order issued by the regulatory agency may be requested in the manner prescribed in sections 14.63 to 14.69. Failure to request a hearing pursuant to subdivision 2 shall constitute a waiver of the right to further agency or judicial review of the final order.

Subd. 4. **Limitations or qualifications placed on license, registration, or permit.** The regulatory agency may, where the facts support such action, place reasonable limitations or qualifications on the right to practice mortuary science ~~or~~, to operate a funeral establishment or crematory, or to conduct activities or actions permitted under this chapter.

Subd. 5. **Restoring license, registration, or permit.** The regulatory agency may, where there is sufficient reason, restore a license, registration, or permit that has been revoked, reduce a period of suspension, or remove limitations or qualifications.

Sec. 59. Minnesota Statutes 2020, section 149A.11, is amended to read:

149A.11 PUBLICATION OF DISCIPLINARY ACTIONS.

The regulatory agencies shall report all disciplinary measures or actions taken to the commissioner. At least annually, the commissioner shall publish and make available to the public a description of all disciplinary measures or actions taken by the regulatory agencies. The publication shall include, for each disciplinary measure or action taken, the name and business address of the licensee, registrant, or intern~~,~~; the nature of the misconduct~~,~~; and the measure or action taken by the regulatory agency.

Sec. 60. **[149A.47] TRANSFER CARE SPECIALIST.**

Subdivision 1. **General.** A transfer care specialist may remove a dead human body from the place of death under the direct supervision of a licensed mortician if the transfer care specialist is registered with the commissioner in accordance with this section. A transfer care specialist is not licensed to engage in the practice of mortuary science and shall not engage in the practice of mortuary science except as provided in this section.

Subd. 2. **Registration.** To be eligible for registration as a transfer care specialist, an applicant must submit to the commissioner:

(1) a complete application on a form provided by the commissioner that includes at a minimum:

(i) the applicant's name, home address and telephone number, business name, and business address and telephone number; and

(ii) the name, license number, business name, and business address and telephone number of the supervising licensed mortician;

(2) proof of completion of a training program that meets the requirements specified in subdivision 4; and

(3) the appropriate fees specified in section 149A.65.

Subd. 3. **Duties.** A transfer care specialist registered under this section is authorized to perform the removal of a dead human body from the place of death in accordance with this chapter to a licensed funeral establishment. The transfer care specialist must work under the direct supervision of a licensed mortician. The supervising mortician is responsible for the work performed by the transfer care specialist. A licensed mortician may supervise up to six transfer care specialists at any one time.

Subd. 4. **Training program.** (a) Each transfer care specialist must complete a training program that has been approved by the commissioner. To be approved, a training program must be at least seven hours long and must cover, at a minimum, the following:

(1) ethical care and transportation procedures for a deceased person;

(2) health and safety concerns to the public and the individual performing the transfer of the deceased person; and

(3) all relevant state and federal laws and regulations related to the transfer and transportation of deceased persons.

(b) A transfer care specialist must complete a training program every five years.

Subd. 5. **Registration renewal.** (a) A registration issued under this section expires one year after the date of issuance and must be renewed to remain valid.

(b) To renew a registration, the transfer care specialist must submit a completed renewal application as provided by the commissioner and the appropriate fees specified in section 149A.65. Every five years, the renewal application must include proof of completion of a training program that meets the requirements in subdivision 4.

Sec. 61. Minnesota Statutes 2020, section 149A.60, is amended to read:

149A.60 PROHIBITED CONDUCT.

The regulatory agency may impose disciplinary measures or take disciplinary action against a person whose conduct is subject to regulation under this chapter for failure to comply with any provision of this chapter or laws, rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, and permits adopted, or issued for the regulation of the removal, preparation, transportation, arrangements for disposition or final disposition of dead human bodies, or for the regulation of the practice of mortuary science.

Sec. 62. Minnesota Statutes 2020, section 149A.61, subdivision 4, is amended to read:

Subd. 4. **Licensees, registrants, and interns.** A licensee, registrant, or intern regulated under this chapter may report to the commissioner any conduct that the licensee, registrant, or intern has personal knowledge of, and reasonably believes constitutes grounds for, disciplinary action under this chapter.

Sec. 63. Minnesota Statutes 2020, section 149A.61, subdivision 5, is amended to read:

Subd. 5. **Courts.** The court administrator of district court or any court of competent jurisdiction shall report to the commissioner any judgment or other determination of the court that adjudges or includes a finding that a licensee, registrant, or intern is a person who is mentally ill, mentally incompetent, guilty of a felony or gross misdemeanor, guilty of violations of federal or state narcotics laws or controlled substances acts; appoints a guardian or conservator for the licensee, registrant, or intern; or commits a licensee, registrant, or intern.

Sec. 64. Minnesota Statutes 2020, section 149A.62, is amended to read:

149A.62 IMMUNITY; REPORTING.

Any person, private agency, organization, society, association, licensee, registrant, or intern who, in good faith, submits information to a regulatory agency under section 149A.61 or otherwise reports violations or alleged violations of this chapter, is immune from civil liability or criminal prosecution. This section does not prohibit disciplinary action taken by the commissioner against any licensee, registrant, or intern pursuant to a self report of a violation.

Sec. 65. Minnesota Statutes 2020, section 149A.63, is amended to read:

149A.63 PROFESSIONAL COOPERATION.

A licensee, clinical student, practicum student, registrant, intern, or applicant for licensure under this chapter that is the subject of or part of an inspection or investigation by the commissioner or the commissioner's designee shall cooperate fully with the inspection or investigation. Failure to cooperate constitutes grounds for disciplinary action under this chapter.

Sec. 66. Minnesota Statutes 2020, section 149A.65, subdivision 2, is amended to read:

Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

(1) $75 for the initial and renewal registration of a mortuary science intern;

(2) $125 for the mortuary science examination;

(3) $200 for issuance of initial and renewal mortuary science licenses;

(4) $100 late fee charge for a license renewal; ~~and~~

(5) $250 for issuing a mortuary science license by endorsement; and

(6) $1,170 for the initial and renewal registration of a transfer care specialist.

Sec. 67. Minnesota Statutes 2020, section 149A.70, subdivision 3, is amended to read:

Subd. 3. **Advertising.** No licensee, registrant, clinical student, practicum student, or intern shall publish or disseminate false, misleading, or deceptive advertising. False, misleading, or deceptive advertising includes, but is not limited to:

(1) identifying, by using the names or pictures of, persons who are not licensed to practice mortuary science in a way that leads the public to believe that those persons will provide mortuary science services;

(2) using any name other than the names under which the funeral establishment, alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

(3) using a surname not directly, actively, or presently associated with a licensed funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had been previously and continuously used by the licensed funeral establishment, alkaline hydrolysis facility, or crematory; and

(4) using a founding or establishing date or total years of service not directly or continuously related to a name under which the funeral establishment, alkaline hydrolysis facility, or crematory is currently or was previously licensed.

Any advertising or other printed material that contains the names or pictures of persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state the position held by the persons and shall identify each person who is licensed or unlicensed under this chapter.

Sec. 68. Minnesota Statutes 2020, section 149A.70, subdivision 4, is amended to read:

Subd. 4. **Solicitation of business.** No licensee shall directly or indirectly pay or cause to be paid any sum of money or other valuable consideration for the securing of business or for obtaining the authority to dispose of any dead human body.

For purposes of this subdivision, licensee includes a registered intern or transfer care specialist or any agent, representative, employee, or person acting on behalf of the licensee.

Sec. 69. Minnesota Statutes 2020, section 149A.70, subdivision 5, is amended to read:

Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student, ~~or~~ intern, or transfer care specialist shall offer, solicit, or accept a commission, fee, bonus, rebate, or other reimbursement in consideration for recommending or causing a dead human

body to be disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis facility, crematory, mausoleum, or cemetery.

Sec. 70. Minnesota Statutes 2020, section 149A.70, subdivision 7, is amended to read:

Subd. 7. **Unprofessional conduct.** No licensee, registrant, or intern shall engage in or permit others under the licensee's, registrant's, or intern's supervision or employment to engage in unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(1) harassing, abusing, or intimidating a customer, employee, or any other person encountered while within the scope of practice, employment, or business;

(2) using profane, indecent, or obscene language within the immediate hearing of the family or relatives of the deceased;

(3) failure to treat with dignity and respect the body of the deceased, any member of the family or relatives of the deceased, any employee, or any other person encountered while within the scope of practice, employment, or business;

(4) the habitual overindulgence in the use of or dependence on intoxicating liquors, prescription drugs, over-the-counter drugs, illegal drugs, or any other mood altering substances that substantially impair a person's work-related judgment or performance;

(5) revealing personally identifiable facts, data, or information about a decedent, customer, member of the decedent's family, or employee acquired in the practice or business without the prior consent of the individual, except as authorized by law;

(6) intentionally misleading or deceiving any customer in the sale of any goods or services provided by the licensee;

(7) knowingly making a false statement in the procuring, preparation, or filing of any required permit or document; or

(8) knowingly making a false statement on a record of death.

Sec. 71. Minnesota Statutes 2020, section 149A.90, subdivision 2, is amended to read:

Subd. 2. **Removal from place of death.** No person subject to regulation under this chapter shall remove or cause to be removed any dead human body from the place of death without being licensed or registered by the commissioner. Every dead human body shall be removed from the place of death by a licensed mortician or funeral director, except as provided in section 149A.01, subdivision 3, or 149A.47.

Sec. 72. Minnesota Statutes 2020, section 149A.90, subdivision 4, is amended to read:

Subd. 4. **Certificate of removal.** No dead human body shall be removed from the place of death by a mortician ~~or~~, funeral director, or transfer care specialist or by a noncompensated person with the right to control the dead human body without the completion of a certificate of removal and, where possible, presentation of a copy of that certificate to the person or a representative of the legal entity with physical or legal custody of the body at the death site. The certificate of removal shall be in the format provided by the commissioner that contains, at least, the following information:

(1) the name of the deceased, if known;

(2) the date and time of removal;

(3) a brief listing of the type and condition of any personal property removed with the body;

(4) the location to which the body is being taken;

(5) the name, business address, and license number of the individual making the removal; and

(6) the signatures of the individual making the removal and, where possible, the individual or representative of the legal entity with physical or legal custody of the body at the death site.

Sec. 73. Minnesota Statutes 2020, section 149A.90, subdivision 5, is amended to read:

Subd. 5. **Retention of certificate of removal.** A copy of the certificate of removal shall be given, where possible, to the person or representative of the legal entity having physical or legal custody of the body at the death site. The original certificate of removal shall be retained by the individual making the removal and shall be kept on file, at the funeral establishment to which the body was taken, for a period of three calendar years following the date of the removal. If the removal was performed by a transfer care specialist not employed by the funeral establishment to which the body was taken, the transfer care specialist shall retain a copy of the certificate on file at the transfer care specialist's business address as registered with the commissioner for a period of three calendar years following the date of removal. Following this period, and subject to any other laws requiring retention of records, the funeral establishment may then place the records in storage or reduce them to microfilm, microfiche, laser disc, or any other method that can produce an accurate reproduction of the original record, for retention for a period of ten calendar years from the date of the removal of the body. At the end of this period and subject to any other laws

requiring retention of records, the funeral establishment may destroy the records by shredding, incineration, or any other manner that protects the privacy of the individuals identified in the records.

Sec. 74. Minnesota Statutes 2020, section 149A.94, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) Every dead human body lying within the state, except unclaimed bodies delivered for dissection by the medical examiner, those delivered for anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through the state for the purpose of disposition elsewhere; and the remains of any dead human body after dissection or anatomical study, shall be decently buried or entombed in a public or private cemetery, alkaline hydrolyzed, or cremated within a reasonable time after death. Where final disposition of a body will not be accomplished within 72 hours following death or release of the body by a competent authority with jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body may not be ~~kept in refrigeration for a period exceeding six calendar days, or~~ packed in dry ice for a period that exceeds four calendar days, from the time of death or release of the body from the coroner or medical examiner. A body may be kept in refrigeration for up to 30 calendar days from the time of death or release of the body from the coroner or medical examiner, provided the dignity of the body is maintained and the funeral establishment complies with paragraph (b) if applicable. A body may be kept in refrigeration for more than 30 calendar days from the time of death or release of the body from the coroner or medical examiner in accordance with paragraphs (c) and (d).

(b) For a body to be kept in refrigeration for between 15 and 30 calendar days, no later than the 14th day of keeping the body in refrigeration the funeral establishment must notify the person with the right to control final disposition that the body will be kept in refrigeration for more than 14 days and that the person with the right to control final disposition has the right to seek other arrangements.

(c) For a body to be kept in refrigeration for more than 30 calendar days, the funeral establishment must:

(1) report at least the following to the commissioner on a form and in a manner prescribed by the commissioner: body identification details determined by the commissioner, the funeral establishment's plan to achieve final disposition of the body within the permitted time frame, and other information required by the commissioner; and

(2) store each refrigerated body in a manner that maintains the dignity of the body.

(d) Each report filed with the commissioner under paragraph (c) authorizes a funeral establishment to keep a body in refrigeration for an additional 30 calendar days.

(e) Failure to submit a report required by paragraph (c) subjects a funeral establishment to enforcement under this chapter.

Sec. 75. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 1a. **Bona fide labor organization.** "Bona fide labor organization" means a labor union that represents or is actively seeking to represent workers of a medical cannabis manufacturer.

Sec. 76. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5d. **Indian lands.** "Indian lands" means all lands within the limits of any Indian reservation within the boundaries of Minnesota and any lands within the boundaries of Minnesota title which are either held in trust by the United States or over which an Indian Tribe exercises governmental power.

Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5e. **Labor peace agreement.** "Labor peace agreement" means an agreement between a medical cannabis manufacturer and a bona fide labor organization that protects the state's interests by, at a minimum, prohibiting the labor organization from engaging in picketing, work stoppages, or boycotts against the manufacturer. This type of agreement shall not mandate a particular method of election or certification of the bona fide labor organization.

Sec. 78. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 15. **Tribal medical cannabis board.** "Tribal medical cannabis board" means an agency established by each federally recognized Tribal government and duly authorized by each Tribe's governing body to perform regulatory oversight and monitor compliance with a Tribal medical cannabis program and applicable regulations.

Sec. 79. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 16. **Tribal medical cannabis program.** "Tribal medical cannabis program" means a program established by a federally recognized Tribal government within the boundaries of Minnesota regarding the commercial production, processing, sale or distribution, and possession of medical cannabis and medical cannabis products.

Sec. 80. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 17. **Tribal medical cannabis program patient.** "Tribal medical cannabis program patient" means a person who possesses a valid registration verification card or equivalent document that is issued under the laws or regulations of a Tribal Nation within the boundaries of Minnesota and that verifies that the person is enrolled in or authorized to participate in that Tribal Nation's Tribal medical cannabis program.

Sec. 81. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

Subdivision 1. **Medical cannabis manufacturer registration and renewal.** (a) The commissioner shall register ~~two~~ at least four and up to ten in-state manufacturers for the production of all medical cannabis within the state. ~~A~~ The registration ~~agreement between the commissioner and a manufacturer~~ is valid for two years, unless revoked under subdivision 1a, and is nontransferable. ~~The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in this subdivision. The commissioner shall accept applications after December 1, 2014, if one of the manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer. The commissioner's determination that no manufacturer exists to fulfill the duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court.~~ Once the commissioner has registered more than two manufacturers, registration renewal for at least one manufacturer must occur each year. The commissioner shall begin registering additional manufacturers by December 1, 2022. The commissioner shall renew a registration if the manufacturer meets the factors described in this subdivision and submits the registration renewal fee under section 152.35.

(b) An individual or entity seeking registration or registration renewal under this subdivision must apply to the commissioner in a form and manner established by the commissioner. As part of the application, the applicant must submit an attestation signed by a bona fide labor organization stating that the applicant has entered into a labor peace

agreement. Before accepting applications for registration or registration renewal, the commissioner must publish on the Office of Medical Cannabis website the application scoring criteria established by the commissioner to determine whether the applicant meets requirements for registration or registration renewal. Data submitted during the application process are private data on individuals or nonpublic data as defined in section 13.02 until the manufacturer is registered under this section. Data on a manufacturer that is registered are public data, unless the data are trade secret or security information under section 13.37.

~~(b)~~ (c) As a condition for registration~~, a manufacturer must agree to~~ or registration renewal:

~~(1) begin supplying medical cannabis to patients by July 1, 2015; and~~

~~(2)~~ (1) a manufacturer must comply with all requirements under sections 152.22 to 152.37~~.~~;

(2) if the manufacturer is a business entity, the manufacturer must be incorporated in the state or otherwise formed or organized under the laws of the state; and

(3) the manufacturer must fulfill commitments made in the application for registration or registration renewal, including but not limited to maintenance of a labor peace agreement.

~~(c)~~ (d) The commissioner shall consider the following factors when determining which manufacturer to register or when determining whether to renew a registration:

(1) the technical expertise of the manufacturer in cultivating medical cannabis and converting the medical cannabis into an acceptable delivery method under section 152.22, subdivision 6;

(2) the qualifications of the manufacturer's employees;

(3) the long-term financial stability of the manufacturer;

(4) the ability to provide appropriate security measures on the premises of the manufacturer;

(5) whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by sections 152.22 to 152.37; ~~and~~

(6) the manufacturer's projection and ongoing assessment of fees on patients with a qualifying medical condition~~.~~;

(7) the manufacturer's inclusion of leadership or beneficial ownership, as defined in section 302A.011, subdivision 41, by:

(i) minority persons as defined in section 116M.14, subdivision 6;

(ii) women;

(iii) individuals with disabilities as defined in section 363A.03, subdivision 12; or

(iv) military veterans who satisfy the requirements of section 197.447;

(8) the extent to which registering the manufacturer or renewing the registration will expand service to a currently underserved market;

(9) the extent to which registering the manufacturer or renewing the registration will promote development in a low-income area as defined in section 116J.982, subdivision 1, paragraph (e);

(10) beneficial ownership as defined in section 302A.011, subdivision 41, of the manufacturer by Minnesota residents; and

(11) other factors the commissioner determines are necessary to protect patient health and ensure public safety.

(e) Commitments made by an applicant in the applicant's application for registration or registration renewal, including but not limited to maintenance of a labor peace agreement, shall be an ongoing material condition of maintaining a manufacturer registration.

~~(d)~~ (f) If an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law under section 152.33, subdivision 1, the commissioner may decide not to renew the registration of the manufacturer, provided the violation occurred while the person was an officer, director, or controlling person of the manufacturer.

~~(e) The commissioner shall require each medical cannabis manufacturer to contract with an independent laboratory to test medical cannabis produced by the manufacturer. The commissioner shall approve the laboratory chosen by each manufacturer and require that the laboratory report testing results to the manufacturer in a manner determined by the commissioner.~~

Sec. 82. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to read:

Subd. 1d. **Background study.** (a) Before the commissioner registers a manufacturer or renews a registration, each officer, director, and controlling person of the manufacturer must consent to a background study and must submit to the commissioner a completed criminal history records check consent form, a full set of classifiable fingerprints, and the

required fees. The commissioner must submit these materials to the Bureau of Criminal Apprehension. The bureau must conduct a Minnesota criminal history records check, and the superintendent is authorized to exchange fingerprints with the Federal Bureau of Investigation to obtain national criminal history record information. The bureau must return the results of the Minnesota and federal criminal history records checks to the commissioner.

(b) The commissioner must not register a manufacturer or renew a registration if an officer, director, or controlling person of the manufacturer has been convicted of, pled guilty to, or received a stay of adjudication for:

(1) a violation of state or federal law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct that is a felony under Minnesota law or would be a felony if committed in Minnesota; or

(2) a violation of state or federal law relating to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance that is a felony under Minnesota law or would be a felony if committed in Minnesota.

Sec. 83. Minnesota Statutes 2020, section 152.29, subdivision 4, is amended to read:

Subd. 4. **Report.** (a) Each manufacturer shall report to the commissioner on a monthly basis the following information on each individual patient for the month prior to the report:

(1) the amount and dosages of medical cannabis distributed;

(2) the chemical composition of the medical cannabis; and

(3) the tracking number assigned to any medical cannabis distributed.

(b) For transactions involving Tribal medical cannabis program patients, each manufacturer shall report to the commissioner on a weekly basis the following information on each individual Tribal medical cannabis program patient for the week prior to the report:

(1) the name of the Tribal medical cannabis program in which the Tribal medical cannabis program patient is enrolled;

(2) the amount and dosages of medical cannabis distributed;

(3) the chemical composition of the medical cannabis; and

(4) the tracking number assigned to the medical cannabis distributed.

Sec. 84. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 5. **Distribution to Tribal medical cannabis program patient.** (a) A manufacturer may distribute medical cannabis in accordance with subdivisions 1 to 4 to a Tribal medical cannabis program patient.

(b) Prior to distribution, the Tribal medical cannabis program patient must provide to the manufacturer:

(1) a valid medical cannabis registration verification card or equivalent document issued by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program patient is authorized to use medical cannabis on Indian lands over which the Tribe has jurisdiction; and

(2) a valid photographic identification card issued by the Tribal medical cannabis program, valid driver's license, or valid state identification card.

(c) A manufacturer shall distribute medical cannabis to a Tribal medical cannabis program patient only in a form allowed under section 152.22, subdivision 6.

Sec. 85. **[152.291] TRIBAL MEDICAL CANNABIS PROGRAM; MANUFACTURERS.**

Subdivision 1. **Manufacturer.** Notwithstanding the requirements and limitations in section 152.29, subdivision 1, paragraph (a), a Tribal medical cannabis program operated by a federally recognized Indian Tribe located in Minnesota shall be recognized as a medical cannabis manufacturer.

Subd. 2. **Manufacturer transportation.** (a) A manufacturer registered with a Tribal medical cannabis program may transport medical cannabis to testing laboratories in the state and to other Indian lands.

(b) A manufacturer registered with a Tribal medical cannabis program must staff a motor vehicle used to transport medical cannabis with at least two employees of the manufacturer. Each employee in the transport vehicle must carry identification specifying that the employee is an employee of the manufacturer, and one employee in the transport vehicle must carry a detailed transportation manifest that includes the place and time of departure, the address of the destination, and a description and count of the medical cannabis being transported.

Sec. 86. Minnesota Statutes 2020, section 152.30, is amended to read:

152.30 PATIENT DUTIES.

(a) A patient shall apply to the commissioner for enrollment in the registry program by submitting an application as required in section 152.27 and an annual registration fee as determined under section 152.35.

(b) As a condition of continued enrollment, patients shall agree to:

(1) continue to receive regularly scheduled treatment for their qualifying medical condition from their health care practitioner; and

(2) report changes in their qualifying medical condition to their health care practitioner.

(c) A patient shall only receive medical cannabis from a registered manufacturer or Tribal medical cannabis program but is not required to receive medical cannabis products from only a registered manufacturer or Tribal medical cannabis program.

Sec. 87. Minnesota Statutes 2020, section 152.32, is amended to read:

152.32 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPATION OR PARTICIPATION IN A TRIBAL MEDICAL CANNABIS PROGRAM.

Subdivision 1. **Presumption.** (a) There is a presumption that a patient enrolled in the registry program under sections 152.22 to 152.37 or a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program is engaged in the authorized use of medical cannabis.

(b) The presumption may be rebutted:

(1) by evidence that a patient's conduct related to use of medical cannabis was not for the purpose of treating or alleviating the patient's qualifying medical condition or symptoms associated with the patient's qualifying medical condition; or

(2) by evidence that a Tribal medical cannabis program patient's use of medical cannabis was not for a purpose authorized by the Tribal medical cannabis program.

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program~~, or~~; possession by a registered designated caregiver or the parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed

on the registry verification; or use or possession of medical cannabis or medical cannabis products by a Tribal medical cannabis program patient;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, members of a Tribal medical cannabis board, the commissioner's or Tribal medical cannabis board's staff, the commissioner's or Tribal medical cannabis board's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37 or in a Tribal medical cannabis program. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient or a Tribal medical cannabis program patient under sections 152.22 to 152.37 may be

admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court, a Tribal court, or the professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37, or for providing legal assistance to a Tribal medical cannabis program.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program, or possession of a verification or equivalent issued by a Tribal medical cannabis program by a person entitled to possess such verification, does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification or equivalent, or otherwise subject the person or property of the person to inspection by any governmental agency.

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 or for the person's status as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program, 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, or a Tribal medical cannabis program patient's use of medical cannabis as authorized by the Tribal medical cannabis program, is considered the equivalent of the authorized use of any other medication used at the discretion of a physician or advanced practice registered nurse 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~~ any 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) the person's status as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program; or

~~(2)~~ (3) 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 or of enrollment in a Tribal medical cannabis program 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 or on the person's status as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program. There shall be no presumption of neglect or child endangerment for conduct allowed under sections 152.22 to 152.37 or under a Tribal medical cannabis program, 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. 88. Minnesota Statutes 2020, section 152.33, subdivision 1, is amended to read:

Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally transfers medical cannabis to a person other than another registered manufacturer, a patient, a registered designated caregiver, a Tribal medical cannabis program patient, or, if listed on the registry verification, a parent, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. A person convicted under this subdivision may not continue to be affiliated with the manufacturer and is disqualified from further participation under sections 152.22 to 152.37.

Sec. 89. Minnesota Statutes 2020, section 152.35, is amended to read:

152.35 FEES; DEPOSIT OF REVENUE.

(a) The commissioner shall collect an enrollment fee of ~~$200~~ $40 from patients enrolled under ~~this~~ section 152.27. ~~If the patient provides evidence of receiving Social Security disability insurance (SSDI), Supplemental Security Income (SSI), veterans disability, or railroad disability payments, or being enrolled in medical assistance or MinnesotaCare, then the fee shall be $50. For purposes of this section:~~

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

~~(2) veterans disability payments include VA dependency and indemnity compensation. Unless a patient provides evidence of receiving payments from or participating in one of the programs specifically listed in this paragraph, the commissioner of health must collect the $200 enrollment fee from a patient to enroll the patient in the registry program.~~ The fees shall be payable annually and are due on the anniversary date of the patient's enrollment. The fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(b) The commissioner shall collect ~~an~~ a registration application fee of $20,000 from each entity submitting an application for registration as a medical cannabis manufacturer. Revenue from the fee shall be deposited in the state treasury and credited to the state government special revenue fund. If the commissioner decides not to register an entity that applies for registration, the commissioner shall reimburse the entity $10,000 of the entity's registration fee no later than 30 days after providing the entity with notice of the decision.

(c) The commissioner shall establish and collect ~~an annual~~ a biennial registration renewal fee from a medical cannabis manufacturer equal to the cost of regulating and inspecting the manufacturer ~~in that year~~ for the upcoming registration period. Revenue from the fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 90. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to read:

Sec. 44. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

(a) The commissioner of health shall develop a grant program, in consultation with the relevant mental health licensing boards, to:

(1) provide for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors to become supervisors for individuals pursuing licensure in mental health professions;

(2) cover the costs when supervision is required for professionals becoming supervisors; and

(3) cover the supervisory costs for mental health practitioners pursuing licensure at the professional level.

(b) Social workers, marriage and family therapists, psychologists, and professional clinical counselors obtaining continuing education and social workers, marriage and family therapists, and clinical counselors needing supervised hours to become licensed under this section must:

(1) be members of communities of color or underrepresented communities as defined in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health professional shortage area; and

(2) ~~work for community mental health providers and~~ agree to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

Sec. 91. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL.**

Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall contract with the University of Minnesota School of Public Health and the Carlson School of Management to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system.

Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of human services and commerce, shall submit to the University of Minnesota for analysis a legislative proposal known as the Minnesota Health Plan that would offer a universal health care plan designed to meet the following principles:

(1) ensure all Minnesotans are covered;

(2) cover all necessary care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the Minnesota Health Plan and the current health care financing system over a ten-year period to contrast the impact on:

(1) the number of people covered versus the number of people who continue to lack access to health care because of financial or other barriers, if any;

(2) the completeness of the coverage and the number of people lacking coverage for dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any;

(3) the adequacy of the coverage, the level of underinsured in the state, and whether people with coverage can afford the care they need or whether cost prevents them from accessing care;

(4) the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) total public and private health care spending in Minnesota under the current system versus under the legislative proposal, including all spending by individuals, businesses, and government. "Total public and private health care spending" means spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources. Total public and private health care spending also includes the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to

select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, long-term care, prescription drugs, medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance. The analysis of total health care spending shall examine whether there are savings or additional costs under the legislative proposal compared to the existing system due to:

(i) reduced insurance, billing, underwriting, marketing, evaluation, and other administrative functions including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) reduced prices on medical services and products including pharmaceuticals due to price negotiations, if applicable under the proposal;

(iii) changes in utilization, better health outcomes, and reduced time away from work due to prevention, early intervention, health-promoting activities, and to the extent possible given available data and resources;

(iv) shortages or excess capacity of medical facilities and equipment under either the current system or the proposal;

(v) the impact on state, local, and federal government non-health-care expenditures such as reduced crime and out-of-home placement costs due to mental health or chemical dependency coverage; and

(vi) job losses or gains in health care delivery, health billing and insurance administration, and elsewhere in the economy under the proposal due to implementation of the reforms and the resulting reduction of insurance and administrative burdens on businesses.

(b) The analysts may consult with authors of the legislative proposal to gain understanding or clarification of the specifics of the proposal. The analysis shall assume that the provisions in the proposal are not preempted by federal law or that the federal government gives a waiver to the preemptions.

(c) The commissioner shall issue a final report by January 15, 2023, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 92. **DIRECTION TO THE COMMISSIONER OF HEALTH; EXPANSION OF THE NURSING WORKFORCE REPORT.**

The commissioner of health shall expand the commissioner's existing license renewal questionnaires authorized under Minnesota Statutes, sections 144.051 and 144.052, to include the collection, analysis, and reporting of data on the following topics:

(1) Minnesota's supply of active licensed registered nurses;

(2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;

(3) reasons licensed registered nurses are leaving direct care positions at hospitals; and

(4) reasons licensed registered nurses are choosing not to renew their licenses and leaving the profession.

Sec. 93. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims Recovery Program.

Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of victims who experienced trauma, including historical trauma, resulting from government-sponsored activities, and to address the health and wellness needs of the families and heirs of these victims.

(b) The commissioner, in consultation with family members of victims who experienced trauma resulting from government-sponsored activities and with community-based organizations that provide culturally appropriate services to victims experiencing trauma and their families, shall award competitive grants to applicants for projects to provide the following services to victims who experienced trauma resulting from government-sponsored activities and their families and heirs:

(1) health and wellness services, which may include services and support to address physical health, mental health, and cultural needs;

(2) remembrance and legacy preservation activities;

(3) cultural awareness services; and

(4) community resources and services to promote healing for victims who experienced trauma resulting from government-sponsored activities and their families and heirs.

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims and families who experienced trauma resulting from government-sponsored activities.

Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. **Report.** By January 15, 2023, the commissioner must submit a status report on the operation and results of the grant program, to the extent possible. The report must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report must include information on grant program activities to date, services offered by grant recipients, and an assessment of the need to continue to offer services to victims, families, and heirs who experienced trauma resulting from government-sponsored activities.

Sec. 94. **IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE; REPORT.**

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers and the amount of low-value care delivered to Minnesota residents. In support of the development of recommendations, the commissioner shall:

(1) review the availability of data and identify gaps in the data infrastructure to estimate aggregated and disaggregated administrative spending and low-value care;

(2) based on available data, estimate the volume and change over time of administrative spending and low-value care in Minnesota;

(3) conduct an environmental scan and key informant interviews with experts in health care finance, health economics, health care management or administration, or the administration of health insurance benefits to identify drivers of spending growth for spending on administrative services or the provision of low-value care; and

(4) convene a clinical learning community and an employer task force to review the evidence from clauses (1) to (3) and develop a set of actionable strategies to address administrative spending volume and growth and the magnitude of the volume of low-value care.

(b) By December 15, 2024, the commissioner shall report the recommendations to the chairs and ranking members of the legislative committees with jurisdiction over health and human services financing and policy.

Sec. 95. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE BEDSIDE ACT.**

(a) By April 1, 2024, each hospital must establish and convene a hospital nurse staffing committee as described under Minnesota Statutes, section 144.7053.

(b) By June 1, 2024, each hospital must implement core staffing plans developed by its hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota Statutes, section 144.7056.

(c) By June 1, 2024, each hospital must submit to the commissioner of health core staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

Sec. 96. **PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

The commissioner shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value-based, global budgeting, or alternative payment systems and recommend steps needed to implement. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs. The commissioner shall develop recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial viability of rural health care systems in the context of spending growth targets. The commissioner shall share findings with the Minnesota Health Care Spending Growth Target Commission.

Sec. 97. **PROGRAM TO DISTRIBUTE COVID-19 TESTS, MASKS, AND RESPIRATORS.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Antigen test" means a lateral flow immunoassay intended for the qualitative detection of nucleocapsid protein antigens from the SARS-CoV-2 virus in nasal swabs, that has emergency use authorization from the United States Food and Drug Administration and that is authorized for nonprescription home use with self-collected nasal swabs.

(c) "COVID-19 test" means a test authorized by the United States Food and Drug Administration to detect the presence of genetic material of the SARS-CoV-2 virus either through a molecular method that detects the RNA or nucleic acid component of the virus, such as polymerase chain reaction or isothermal amplification, or through a rapid lateral flow immunoassay that detects the nucleocapsid protein antigens from the SARS-CoV-2 virus.

(d) "KN95 respirator" means a type of filtering facepiece respirator that is commonly made and used in China, is designed and tested to meet an international standard, and does not include an exhalation valve.

(e) "Mask" means a face covering intended to contain droplets and particles in a person's breath, cough, or sneeze.

(f) "Respirator" means a face covering that filters the air and fits closely on the face to filter out particles, including the SARS-CoV-2 virus.

Subd. 2. **Program established.** In order to help reduce the number of cases of COVID-19 in the state, the commissioner of health must administer a program to distribute to individuals in Minnesota, COVID-19 tests, including antigen tests; and masks and respirators, including KN95 respirators and similar respirators approved by the Centers for Disease Control and Prevention and authorized by the commissioner for distribution under this program. Masks and respirators distributed under this program may include child-sized masks and respirators, if such masks and respirators are available and the commissioner finds there is a need for them. COVID-19 tests, masks, and respirators must be distributed at no cost to the individuals receiving them and may be shipped directly to individuals; distributed through local health departments, COVID community coordinators, and other community-based organizations; and distributed through other means determined by the commissioner. The commissioner may prioritize distribution under this section to communities and populations who are disproportionately impacted by COVID-19 or who have difficulty accessing COVID-19 tests, masks, or respirators.

Subd. 3. **Process to order COVID-19 tests, masks, and respirators.** The commissioner may establish a process for individuals to order COVID-19 tests, masks, and respirators to be shipped directly to the individual.

Subd. 4. **Notice.** An entity distributing KN95 respirators or similar respirators under this section may include with the respirators a notice that individuals with a medical condition that may make it difficult to wear a KN95 respirator or similar respirator should consult with a health care provider before use.

Subd. 5. **Coordination.** The commissioner may coordinate this program with other state and federal programs that distribute COVID-19 tests, masks, or respirators to the public.

Sec. 98. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

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

(c) "Non-claims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2023, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and non-claims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are non-claims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of non-claims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section are nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 99. **SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM CARE FACILITIES.**

Subdivision 1. **Temporary grant program for long-term care safety improvements.** The commissioner of health shall develop, implement, and manage a temporary, competitive grant process for state-licensed long-term care facilities to improve their ability to reduce the transmission of COVID-19 or other similar conditions.

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

(b) "Eligible facility" means:

(1) an assisted living facility licensed under chapter 144G;

(2) a supervised living facility licensed under chapter 144;

(3) a board and care facility that is not federally certified and is licensed under chapter 144; and

(4) a nursing home that is not federally certified and is licensed under chapter 144A.

(c) "Eligible project" means a modernization project to update, remodel or replace outdated equipment, systems, technology, or physical spaces.

Subd. 3. **Program.** (a) The commissioner of health shall award improvement grants to an eligible facility. An improvement grant shall not exceed $1,250,000.

(b) Funds may be used to improve the safety, quality of care, and livability of aging infrastructure in a Department of Health licensed eligible facility with an emphasis on reducing the transmission risk of COVID-19 and other infections. Projects include but are not limited to:

(1) heating, ventilation, and air-conditioning systems improvements to reduce airborne exposures;

(2) physical space changes for infection control; and

(3) technology improvements to reduce social isolation and improve resident or client well-being.

(c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not lapse until expended by the grantee.

Subd. 4. **Applications.** An eligible facility seeking a grant shall apply to the commissioner. The application must include a description of the resident population demographics, the problem the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, including any in-kind resources, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organization. An applicant must submit to the commissioner evidence that competitive bidding was used to select contractors for the project.

Subd. 5. **Consideration of applications.** The commissioner shall review each application to determine if the application is complete and if the facility and the project are eligible for a grant. In evaluating applications, the commissioner shall develop a standardized scoring

system that assesses: (1) the applicant's understanding of the problem, description of the project and the likelihood of a successful outcome of the project; (2) the extent to which the project will reduce the transmission of COVID-19; (3) the extent to which the applicant has demonstrated that it has made adequate provisions to ensure proper and efficient operation of the facility once the project is completed; (4) and other relevant factors as determined by the commissioner. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible facility based on the relative score of each eligible facility's application, other relevant factors discussed during the review, and the funds available to the commissioner. During the grant period and within one year after completion of the grant period, the commissioner may collect from an eligible facility receiving a grant, any information necessary to evaluate the program.

Subd. 7. **Expiration.** This section expires June 30, 2025.

Sec. 100. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment preferences of a patient with an advanced serious illness who is nearing the end of the their life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Study.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall study the issues related to creating a statewide registry

of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner, for the provision of care or services.

(b) As a part of the study, the commissioner shall develop recommendations on the following:

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit a report on the results of the study, including recommendations on establishing a statewide registry of POLST forms, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2023.

Sec. 101. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article 3, section 44, as Minnesota Statutes, section 144.1504. The revisor of statutes may make any necessary cross-reference changes.

(b) The revisor of statutes shall correct cross-references in Minnesota Statutes to conform with the relettering of paragraphs in Minnesota Statutes, section 144.1501, subdivision 1.

(c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b) to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051. The revisor shall make any necessary changes to sentence structure for this renumbering

while preserving the meaning of the text. The revisor shall also make necessary cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the renumbering.

(d) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

(e) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

ARTICLE 2
DEPARTMENT OF HEALTH POLICY

Section 1. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the federal database MDS assessments that conform with the assessment schedule defined by the Long Term Care Facility Resident Assessment Instrument User's Manual, version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments required under the Omnibus Budget Reconciliation Act of 1987 (OBRA) used to determine a case mix classification for reimbursement include ~~the following~~:

(1) a new admission comprehensive assessment, which must have an assessment reference date (ARD) within 14 calendar days after admission, excluding readmissions;

(2) an annual comprehensive assessment, which must have an ARD within 92 days of a previous quarterly review assessment or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must have an ARD within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement

or a decline, and regardless of the amount of time since the last comprehensive assessment or quarterly review assessment;

(4) a quarterly review assessment must have an ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification;

(6) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for RUG classification;

(7) a required significant change in status assessment when:

(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA comprehensive or quarterly assessment completed does not result in a rehabilitation case mix classification, then the significant change in status assessment is not required. The ARD of this assessment must be set on day eight after all therapy services have ended; and

(ii) isolation for an infectious disease has ended. If isolation was not coded on the most recent OBRA comprehensive or quarterly assessment completed, then the significant change in status assessment is not required. The ARD of this assessment must be set on day 15 after isolation has ended; and

(8) any modifications to the most recent assessments under clauses (1) to (7).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2020, section 144.1201, subdivision 2, is amended to read:

Subd. 2. **~~By-product nuclear~~ Byproduct material.** "~~By-product nuclear~~ Byproduct material" means ~~a radioactive material, other than special nuclear material, yielded in or made radioactive by exposure to radiation created incident to the process of producing or utilizing special nuclear material.~~:

(1) any radioactive material, except special nuclear material, yielded in or made radioactive by exposure to the radiation incident to the process of producing or using special nuclear material;

(2) the tailings or wastes produced by the extraction or concentration of uranium or thorium from ore processed primarily for its source material content, including discrete surface wastes resulting from uranium solution extraction processes. Underground ore bodies depleted by these solution extraction operations do not constitute byproduct material within this definition;

(3) any discrete source of radium-226 that is produced, extracted, or converted after extraction for commercial, medical, or research activity, or any material that:

(i) has been made radioactive by use of a particle accelerator; and

(ii) is produced, extracted, or converted after extraction for commercial, medical, or research activity; and

(4) any discrete source of naturally occurring radioactive material, other than source nuclear material, that:

(i) the United States Nuclear Regulatory Commission, in consultation with the Administrator of the Environmental Protection Agency, the Secretary of Energy, the Secretary of Homeland Security, and the head of any other appropriate federal agency determines would pose a threat similar to the threat posed by a discrete source of radium-226 to the public health and safety or the common defense and security; and

(ii) is extracted or converted after extraction for use in a commercial, medical, or research activity.

Sec. 3. Minnesota Statutes 2020, section 144.1201, subdivision 4, is amended to read:

Subd. 4. **Radioactive material.** "Radioactive material" means a matter that emits radiation. Radioactive material includes special nuclear material, source nuclear material, and ~~by-product nuclear~~ byproduct material.

Sec. 4. Minnesota Statutes 2021 Supplement, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~16-member~~ 21-member Rural Health Advisory Committee. The committee shall consist

of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

(7) a dentist licensed under chapter 150A;

(8) ~~a midlevel practitioner~~ an advanced practice provider;

(9) a registered nurse or licensed practical nurse;

(10) a licensed health care professional from an occupation not otherwise represented on the committee;

(11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; ~~and~~

(12) a member of a Tribal nation;

(13) a representative of a local public health agency or community health board;

(14) a health professional or advocate with experience working with people with mental illness;

(15) a representative of a community organization that works with individuals experiencing health disparities;

(16) an individual with expertise in economic development, or an employer working outside the seven-county metropolitan area; and

~~(12)~~ (17) three consumers, at least one of whom must be ~~an advocate for persons who are mentally ill or developmentally disabled~~ from a community experiencing health disparities.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

Sec. 5. Minnesota Statutes 2020, section 144.497, is amended to read:

144.497 ST ELEVATION MYOCARDIAL INFARCTION.

The commissioner of health shall assess ~~and report on~~ the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual; and

~~(2) quarterly post a summary report of the data in aggregate form on the Department of Health website;~~

~~(3) annually inform the legislative committees with jurisdiction over public health of progress toward improving the quality of care and patient outcomes for ST elevation myocardial infarctions; and~~

~~(4)~~ (2) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.

Sec. 6. Minnesota Statutes 2021 Supplement, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or

complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of this item may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission;

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added;

(29) upon submission of a plan to the commissioner for public interest review under section 144.552 and the addition of the 15 inpatient mental health beds specified in clause (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. Five of the 45 additional beds authorized under this clause must be designated for use for inpatient mental health and must be added to the hospital's bed capacity before the remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552; ~~or~~

(30) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital

in Hennepin County that exclusively provides care to patients who are under 21 years of age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552.;

(31) a project to add licensed beds in a hospital in Cook County that: (i) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of licensed beds in the hospital after the bed addition does not exceed 25 beds; or

(32) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's hospital in St. Paul that is part of an independent pediatric health system with freestanding inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public interest review described in section 144.552.

Sec. 7. Minnesota Statutes 2020, section 144.565, subdivision 4, is amended to read:

Subd. 4. **Definitions.** (a) For purposes of this section, the following terms have the meanings given:.

(b) "Diagnostic imaging facility" means a health care facility that is not a hospital or location licensed as a hospital which offers diagnostic imaging services in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center. A dental clinic or office is not considered a diagnostic imaging facility for the purpose of this section when the clinic or office performs diagnostic imaging through dental cone beam computerized tomography.

(c) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT) other than dental cone beam computerized tomography, positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

(d) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

(e) "Fixed equipment" means a stationary diagnostic imaging machine installed in a permanent location.

(f) "Mobile equipment" means a diagnostic imaging machine in a self-contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(g) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(h) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Sec. 8. Minnesota Statutes 2020, section 144.586, is amended by adding a subdivision to read:

Subd. 4. **Screening for eligibility for health coverage or assistance.** (a) A hospital must screen a patient who is uninsured or whose insurance coverage status is not known by the hospital, for eligibility for charity care from the hospital, eligibility for state or federal public health care programs using presumptive eligibility or another similar process, and eligibility for a premium tax credit. The hospital must attempt to complete this screening process in person or by telephone within 30 days after the patient's admission to the hospital.

(b) If the patient is eligible for charity care from the hospital, the hospital must assist the patient in applying for charity care and must refer the patient to the appropriate department in the hospital for follow-up.

(c) If the patient is presumptively eligible for a public health care program, the hospital must assist the patient in completing an insurance affordability program application, help schedule an appointment for the patient with a navigator organization, or provide the patient with contact information for navigator services. If the patient is eligible for a premium tax credit, the hospital may schedule an appointment for the patient with a navigator organization or provide the patient with contact information for navigator services.

(d) A patient may decline to participate in the screening process, to apply for charity care, to complete an insurance affordability program application, to schedule an appointment with a navigator organization, or to accept information about navigator services.

(e) For purposes of this subdivision:

(1) "hospital" means a private, nonprofit, or municipal hospital licensed under sections 144.50 to 144.56;

(2) "navigator" has the meaning given in section 62V.02, subdivision 9;

(3) "premium tax credit" means a tax credit or premium subsidy under the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to and federal guidance and regulations issued under these acts; and

(4) "presumptive eligibility" has the meaning given in section 256B.057, subdivision 12.

EFFECTIVE DATE. This section is effective November 1, 2022.

Sec. 9. Minnesota Statutes 2020, section 144.6502, subdivision 1, is amended to read:

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

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

(c) "Department" means the Department of Health.

(d) "Electronic monitoring" means the placement and use of an electronic monitoring device ~~by a resident~~ in the resident's room or private living unit in accordance with this section.

(e) "Electronic monitoring device" means a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living unit.

(f) "Facility" means a facility that is:

(1) licensed as a nursing home under chapter 144A;

(2) licensed as a boarding care home under sections 144.50 to 144.56;

(3) until August 1, 2021, a housing with services establishment registered under chapter 144D that is either subject to chapter 144G or has a disclosed special unit under section 325F.72; or

(4) on or after August 1, 2021, an assisted living facility.

(g) "Resident" means a person 18 years of age or older residing in a facility.

(h) "Resident representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian;

(2) a health care agent as defined in section 145C.01, subdivision 2; or

(3) a person who is not an agent of a facility or of a home care provider designated in writing by the resident and maintained in the resident's records on file with the facility.

Sec. 10. Minnesota Statutes 2020, section 144.651, is amended by adding a subdivision to read:

Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider and a health care facility must allow, at a minimum, one designated support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services including during a hospital stay.

(b) For purposes of this subdivision, "designated support person" means any person necessary to provide comfort to the patient including but not limited to the patient's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

Sec. 11. Minnesota Statutes 2020, section 144.69, is amended to read:

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Subdivision 1. **Data collected by the cancer reporting system.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer ~~surveillance~~ reporting 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~~ notifying the attending physician, advanced practice registered nurse, or surgeon ~~is obtained~~.

Subd. 2. **Transfers of information to non-Minnesota state and federal government agencies.** (a) Information containing personal identifiers collected by the cancer reporting system may be provided to the statewide cancer registry of other states solely for the purposes consistent with this section and sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the classification of the information as provided under subdivision 1.

(b) Information, excluding direct identifiers such as name, Social Security number, telephone number, and street address, collected by the cancer reporting system may be provided to the Centers for Disease Control and Prevention's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results Program registry.

Sec. 12. Minnesota Statutes 2021 Supplement, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab team services, or interim controls undertaken to make a residence, child care facility, school, playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

(b) Lead hazard reduction does not include renovation activity that is primarily intended to remodel, repair, or restore a given structure or dwelling rather than abate or control lead-based paint hazards.

(c) Lead hazard reduction does not include activities that disturb painted surfaces that total:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than two square feet (0.2 square meters) in an interior room.

Sec. 13. Minnesota Statutes 2020, section 144.9501, subdivision 26a, is amended to read:

Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services;

(9) swab team services;

(10) renovation activities; ~~or~~

(11) lead hazard reduction; or

~~(11)~~ (12) activities performed to comply with lead orders issued by ~~a community health board~~ an assessing agency.

~~(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:~~

~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

~~(2) six square feet (0.6 square meters) in an interior room.~~

Sec. 14. Minnesota Statutes 2020, section 144.9501, subdivision 26b, is amended to read:

Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978 affected property for compensation that results in the disturbance of known or presumed lead-containing painted surfaces defined under section 144.9508, unless that activity is performed as lead hazard reduction. A renovation performed for the purpose of converting

a building or part of a building into an affected property is a renovation under this subdivision.

(b) Renovation does not include activities that disturb painted surfaces that total:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than six square feet (0.6 square meters) in an interior room.

Sec. 15. Minnesota Statutes 2020, section 144.9505, subdivision 1, is amended to read:

Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this section shall be deposited into the state treasury and credited to the state government special revenue fund.

(b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, renovation firms, or lead firms unless they have licenses or certificates issued by the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) An individual who is the owner of property on which ~~regulated lead work~~ lead hazard reduction is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.

(e) A person that employs individuals to perform ~~regulated lead work~~ lead hazard reduction, clearance inspections, lead risk assessments, lead inspections, lead hazard screens, lead project designer services, lead sampling technician services, and swab team services outside of the person's property must obtain certification as a certified lead firm. An individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, clearance inspections, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other individuals~~,~~; the individual is employed by a person that does not perform ~~regulated lead work~~ lead hazard reduction, clearance inspections, lead risk assessments, lead inspections, lead hazard screens, lead project designer services, lead sampling technician services, and swab team services outside of the person's property~~,~~; or the individual is employed by an assessing agency.

Sec. 16. Minnesota Statutes 2020, section 144.9505, subdivision 1h, is amended to read:

Subd. 1h. **Certified renovation firm.** A person who ~~employs individuals to perform~~ performs renovation activities ~~outside of the person's property~~ must obtain certification as a renovation firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A renovation firm certificate is valid for two years. The certification fee is $100, is nonrefundable, and must be submitted with each application. The renovation firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Sec. 17. Minnesota Statutes 2020, section 144A.01, is amended to read:

144A.01 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144A.01 to 144A.27, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner of health.** "Commissioner of health" means the state commissioner of health established by section 144.011.

Subd. 3. **Board of Executives for Long Term Services and Supports.** "Board of Executives for Long Term Services and Supports" means the Board of Executives for Long Term Services and Supports established by section 144A.19.

Subd. 3a. **Certified.** "Certified" means certified for participation as a provider in the Medicare or Medicaid programs under title XVIII or XIX of the Social Security Act.

Subd. 4. **Controlling ~~person~~ individual.** (a) "Controlling ~~person~~ individual" means ~~any public body, governmental agency, business entity,~~ an owner and the following individuals and entities, if applicable:

(1) each officer of the organization, including the chief executive officer and the chief financial officer;

(2) the nursing home administrator~~,~~; or ~~director whose responsibilities include the direction of the management or policies of a nursing home~~

(3) any managerial official.

(b) "Controlling ~~person~~ individual" also means any entity or natural person who~~, directly or indirectly, beneficially owns any~~ has any direct or indirect ownership interest in:

(1) any corporation, partnership or other business association which is a controlling ~~person~~ individual;

(2) any other legal or business entity;

~~(2)~~ (3) the land on which a nursing home is located;

~~(3)~~ (4) the structure in which a nursing home is located;

~~(4)~~ (5) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other ~~obligation secured in whole or part by~~ security interest in the land or structure comprising a nursing home; or

~~(5)~~ (6) any lease or sublease of the land, structure, or facilities comprising a nursing home.

~~(b)~~ (c) "Controlling ~~person~~ individual" does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

(2) government and government-sponsored entities such as the United States Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

~~(2)~~ (3) an individual who is a state or federal official ~~or~~, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state ~~which~~ or federal government that operates one or more nursing homes, unless the individual is also an officer ~~or director of a~~, owner, or managerial official of the nursing home, receives any remuneration from a nursing home, or ~~owns any of the beneficial interests~~ who is a controlling individual not otherwise excluded in this subdivision;

~~(3)~~ (4) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also ~~an officer or director of a nursing home, or owns any of the beneficial interests~~ a controlling individual not otherwise excluded in this subdivision; and

~~(4)~~ (5) a natural person who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt by virtue of section 80A.45, clause (6); or

(ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

Subd. 4a. **Emergency.** "Emergency" means a situation or physical condition that creates or probably will create an immediate and serious threat to a resident's health or safety.

Subd. 5. **Nursing home.** "Nursing home" means a facility or that part of a facility which provides nursing care to five or more persons. "Nursing home" does not include a facility or that part of a facility which is a hospital, a hospital with approved swing beds as defined in section 144.562, clinic, doctor's office, diagnostic or treatment center, or a residential program licensed pursuant to sections 245A.01 to 245A.16 or 252.28.

Subd. 6. **Nursing care.** "Nursing care" means health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis. The commissioner of health may by rule establish levels of nursing care.

Subd. 7. **Uncorrected violation.** "Uncorrected violation" means a violation of a statute or rule or any other deficiency for which a notice of noncompliance has been issued and fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 8.

Subd. 8. **Managerial ~~employee~~ official.** "Managerial ~~employee~~ official" means an ~~employee of a~~ individual who has the decision-making authority related to the operation of the nursing home ~~whose duties include~~ and the responsibility for either: (1) the ongoing management of the nursing home; or (2) the direction of ~~some or all of the management or~~ policies, services, or employees of the nursing home.

Subd. 9. **Nursing home administrator.** "Nursing home administrator" means a person who administers, manages, supervises, or is in general administrative charge of a nursing home, whether or not the individual has an ownership interest in the home, and whether or not the person's functions and duties are shared with one or more individuals, and who is licensed pursuant to section 144A.21.

Subd. 10. **Repeated violation.** "Repeated violation" means the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule.

Subd. 11. **Change of ownership.** "Change of ownership" means a change in the licensee.

Subd. 12. **Direct ownership interest.** "Direct ownership interest" means an individual or legal entity with the possession of at least five percent equity in capital, stock, or profits of the licensee or who is a member of a limited liability company of the licensee.

Subd. 13. **Indirect ownership interest.** "Indirect ownership interest" means an individual or legal entity with a direct ownership interest in an entity that has a direct or indirect ownership interest of at least five percent in an entity that is a licensee.

Subd. 14. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner issues a license for a nursing home and who is responsible for the management, control, and operation of the nursing home.

Subd. 15. **Management agreement.** "Management agreement" means a written, executed agreement between a licensee and manager regarding the provision of certain services on behalf of the licensee.

Subd. 16. **Manager.** "Manager" means an individual or legal entity designated by the licensee through a management agreement to act on behalf of the licensee in the on-site management of the nursing home.

Subd. 17. **Managing control.** "Managing control" means any organization that exercises operational or managerial control over the nursing home or conducts the day-to-day operations of the nursing home.

Subd. 18. **Owner.** "Owner" means: (1) an individual or legal entity that has a direct or indirect ownership interest of five percent or more in a licensee; and (2) for purposes of this chapter, owner of a nonprofit corporation means the president and treasurer of the board of directors; and (3) for an entity owned by an employee stock ownership plan, owner means the president and treasurer of the entity. A government entity that is issued a license under this chapter shall be designated the owner.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 18. Minnesota Statutes 2020, section 144A.03, subdivision 1, is amended to read:

Subdivision 1. **Form; requirements.** (a) The commissioner of health by rule shall establish forms and procedures for the processing of nursing home license applications.

(b) An application for a nursing home license shall include ~~the following information~~:

(1) the ~~names~~ business name and ~~addresses of all controlling persons and managerial employees of the facility to be licensed~~ legal entity name of the licensee;

(2) the street address, mailing address, and legal property description of the facility;

(3) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the nursing home administrator;

(4) the name and e-mail address of the managing agent and manager, if applicable;

(5) the licensed bed capacity;

(6) the license fee in the amount specified in section 144.122;

(7) documentation of compliance with the background study requirements in section 144.057 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;

~~(3)~~ (8) a copy of the architectural and engineering plans and specifications of the facility as prepared and certified by an architect or engineer registered to practice in this state; ~~and~~

(9) a copy of the executed lease agreement between the landlord and the licensee, if applicable;

(10) a copy of the management agreement, if applicable;

(11) a copy of the operations transfer agreement or similar agreement, if applicable;

(12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other;

(13) whether the applicant, owner, controlling individual, managerial official, or nursing home administrator of the facility has ever been convicted of:

(i) a crime or found civilly liable for a federal or state felony-level offense that was detrimental to the best interests of the facility and its residents within the last ten years preceding submission of the license application. Offenses include: (A) felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; (B) financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; (C) any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and (D) any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act;

(ii) any misdemeanor under federal or state law related to the delivery of an item or service under Medicaid or a state health care program or the abuse or neglect of a patient in connection with the delivery of a health care item or service;

(iii) any misdemeanor under federal or state law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service;

(iv) any felony or misdemeanor under federal or state law relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201;

(v) any felony or misdemeanor under federal or state law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or

(vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period;

(14) whether the applicant, owner, controlling individual, managerial official, or nursing home administrator of the facility has had:

(i) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of the license while a formal disciplinary proceeding was pending before a state licensing authority;

(ii) any revocation or suspension of accreditation; or

(iii) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program or any debarment from participation in any federal executive branch procurement or nonprocurement program;

(15) whether in the preceding three years the applicant or any owner, controlling individual, managerial official, or nursing home administrator of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings;

(16) the signature of the owner of the licensee or an authorized agent of the licensee;

(17) identification of all states where the applicant or individual having a five percent or more ownership currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where the applicant's or individual's license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership or where these same actions are pending under the laws of any state or federal authority;

(18) statistical information required by the commissioner; and

~~(4)~~ (19) any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license.

(c) A controlling ~~person~~ individual which is a corporation shall submit copies of its articles of incorporation and bylaws and any amendments thereto as they occur, together with the names and addresses of its officers and directors. A controlling ~~person~~ individual which is a foreign corporation shall furnish the commissioner of health with a copy of its certificate of authority to do business in this state. ~~An application on behalf of a controlling person which is a corporation, association or a governmental unit or instrumentality shall be signed by at least two officers or managing agents of that entity.~~

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 19. Minnesota Statutes 2020, section 144A.04, subdivision 4, is amended to read:

Subd. 4. **Controlling ~~person~~ individual restrictions.** (a) The commissioner has discretion to bar any controlling ~~persons~~ individual of a nursing home ~~may not include any~~ if the person ~~who~~ was a controlling ~~person~~ individual of ~~another~~ any other nursing home ~~during any period of time~~, assisted living facility, long-term care or health care facility, or agency in the previous two-year period and:

(1) during ~~which~~ that period of time ~~of control that other nursing home~~ the facility or agency incurred the following number of uncorrected or repeated violations:

(i) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident or client care or safety; or

(ii) four or more uncorrected violations or two or more repeated violations ~~of any nature for which the fines are in the four highest daily fine categories prescribed in rule~~ that created an imminent risk to direct resident or client care or safety; or

(2) ~~who~~ during that period of time, was convicted of a felony or gross misdemeanor that ~~relates~~ related to operation of the ~~nursing home~~ facility or agency or directly ~~affects~~ affected resident safety or care~~, during that period~~.

(b) The provisions of this subdivision shall not apply to any controlling ~~person~~ individual who had no legal authority to affect or change decisions related to the operation of the nursing home which incurred the uncorrected violations.

(c) When the commissioner bars a controlling individual under this subdivision, the controlling individual has the right to appeal under chapter 14.

Sec. 20. Minnesota Statutes 2020, section 144A.04, subdivision 6, is amended to read:

Subd. 6. **Managerial ~~employee~~ official or licensed administrator; employment prohibitions.** A nursing home may not employ as a managerial ~~employee~~ official or as its licensed administrator any person who was a managerial ~~employee~~ official or the licensed administrator of another facility during any period of time in the previous two-year period:

(1) during which time of employment that other nursing home incurred the following number of uncorrected violations which were in the jurisdiction and control of the managerial ~~employee~~ official or the administrator:

(i) two or more uncorrected violations ~~or one or more repeated violations which created an imminent risk to direct resident care or safety~~; or

(ii) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule; or

(2) who was convicted of a felony or gross misdemeanor that relates to operation of the nursing home or directly affects resident safety or care, during that period.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 21. Minnesota Statutes 2020, section 144A.06, is amended to read:

144A.06 TRANSFER OF ~~INTERESTS~~ LICENSE PROHIBITED.

Subdivision 1. **~~Notice; expiration of license~~ Transfers prohibited.** ~~Any controlling person who makes any transfer of a beneficial interest in a nursing home shall notify the commissioner of health of the transfer within 14 days of its occurrence. The notification shall identify by name and address the transferor and transferee and shall specify the nature and amount of the transferred interest. On determining that the transferred beneficial interest exceeds ten percent of the total beneficial interest in the nursing home facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner may, and on determining that the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner shall require that the license of the nursing home expire 90 days after the date of transfer. The commissioner of health shall notify the nursing home by certified mail of the expiration of the license at least 60 days prior to the date of expiration.~~ A nursing home license may not be transferred.

Subd. 2. **~~Relicensure~~ New license required; change of ownership.** (a) The commissioner of health by rule shall prescribe procedures for ~~relicensure~~ licensure under

this section. ~~The commissioner of health shall relicense a nursing home if the facility satisfies the requirements for license renewal established by section 144A.05. A facility shall not be relicensed by the commissioner if at the time of transfer there are any uncorrected violations. The commissioner of health may temporarily waive correction of one or more violations if the commissioner determines that:~~

~~(1) temporary noncorrection of the violation will not create an imminent risk of harm to a nursing home resident; and~~

~~(2) a controlling person on behalf of all other controlling persons:~~

~~(i) has entered into a contract to obtain the materials or labor necessary to correct the violation, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to correct the violation is due solely to that failure; or~~

~~(ii) is otherwise making a diligent good faith effort to correct the violation.~~

(b) A new license is required and the prospective licensee must apply for a license prior to operating a currently licensed nursing home. The licensee must change whenever one of the following events occur:

(1) the form of the licensee's legal entity structure is converted or changed to a different type of legal entity structure;

(2) the licensee dissolves, consolidates, or merges with another legal organization and the licensee's legal organization does not survive;

(3) within the previous 24 months, 50 percent or more of the licensee's ownership interest is transferred, whether by a single transaction or multiple transactions to:

(i) a different person; or

(ii) a person who had less than a five percent ownership interest in the facility at the time of the first transaction; or

(4) any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's responsibility for the facility.

Subd. 3. **Compliance.** The commissioner must consult with the commissioner of human services regarding the history of financial and cost reporting compliance of the prospective licensee and prospective licensee's financial operations in any nursing home that the prospective licensee or any controlling individual listed in the license application has had an interest in.

Subd. 4. **Facility operation.** The current licensee remains responsible for the operation of the nursing home until the nursing home is licensed to the prospective licensee.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 22. **[144A.32] CONSIDERATION OF APPLICATIONS.**

(a) Before issuing a provisional license or license or renewing an existing license, the commissioner shall consider an applicant's compliance history in providing care in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violations, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license is granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect the applicant's books, records, files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way:

(i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or

(ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter or chapter 256R.

(d) If a license is denied, the applicant has the reconsideration rights available under chapter 14.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 23. Minnesota Statutes 2020, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint ~~eight~~ 12 persons to a home care and assisted living program advisory council consisting of the following:

(1) ~~three~~ two public members as defined in section 214.02 who shall be persons who are currently receiving home care services, persons who have received home care services within five years of the application date, persons who have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) ~~three~~ two Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing;

(4) one member representing the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; ~~and~~

(5) beginning July 1, 2021, one member of a county health and human services or county adult protection office~~.~~;

(6) two Minnesota assisted living facility licensees representing assisted living facilities and assisted living facilities with dementia care levels of licensure who may be the facility's assisted living director, managerial official, or clinical nurse supervisor;

(7) one organization representing long-term care providers, home care providers, and assisted living providers in Minnesota; and

(8) two public members as defined in section 214.02. One public member shall be a person who either is or has been a resident in an assisted living facility and one public member shall be a person who has or had a family member living in an assisted living facility setting.

Sec. 24. Minnesota Statutes 2020, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed assisted living and home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care and assisted living services defined under chapter 144G;

(4) training standards;

(5) identifying emerging issues and opportunities in home care and assisted living services defined under chapter 144G;

(6) identifying the use of technology in home and telehealth capabilities;

(7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually make recommendations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and include but are not limited to projects that create and administer training of licensees and their employees to improve residents' lives, supporting ways that licensees can improve and enhance quality care and ways to provide technical assistance to licensees to improve compliance; information technology and data projects that analyze and communicate information about trends of violations or lead to ways of improving client care; communications strategies to licensees and the public; and other projects or pilots that benefit clients, families, and the public.

Sec. 25. Minnesota Statutes 2020, section 144A.75, subdivision 12, is amended to read:

Subd. 12. **Palliative care.** "Palliative care" means ~~the total active care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount~~ specialized medical care for people living with a serious illness or life-limiting condition. This type of care is focused

on reducing the pain, symptoms, and stress of a serious illness or condition. Palliative care is a team-based approach to care, providing essential support at any age or stage of a serious illness or condition, and is often provided together with curative treatment. The goal of palliative care is ~~the achievement of the best quality of life for patients and their families~~ to improve quality of life for both the patient and the patient's family or care partner.

Sec. 26. Minnesota Statutes 2020, section 144G.08, is amended by adding a subdivision to read:

Subd. 62a. **Serious injury.** "Serious injury" has the meaning given in section 245.91, subdivision 6.

Sec. 27. Minnesota Statutes 2020, section 144G.15, is amended to read:

144G.15 CONSIDERATION OF APPLICATIONS.

(a) Before issuing a provisional license or license or renewing a license, the commissioner shall consider an applicant's compliance history in providing care in this state or any other state in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violation, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect its books, records, and files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or (ii)

the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant, owner, controlling individual, managerial official, or assisted living director for the facility has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter.

(d) If a license is denied, the applicant has the reconsideration rights available under section 144G.16, subdivision 4.

Sec. 28. Minnesota Statutes 2020, section 144G.17, is amended to read:

144G.17 LICENSE RENEWAL.

A license that is not a provisional license may be renewed for a period of up to one year if the licensee:

(1) submits an application for renewal in the format provided by the commissioner at least 60 calendar days before expiration of the license;

(2) submits the renewal fee under section 144G.12, subdivision 3;

(3) submits the late fee under section 144G.12, subdivision 4, if the renewal application is received less than 30 days before the expiration date of the license or after the expiration of the license;

(4) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under section 144G.12, subdivision 1; ~~and~~

(5) provides information sufficient to show the licensee provided assisted living services to at least one resident during the immediately preceding license year and at the assisted living facility listed on the license; and

~~(5)~~ (6) provides any other information deemed necessary by the commissioner.

Sec. 29. Minnesota Statutes 2020, section 144G.19, is amended by adding a subdivision to read:

Subd. 4. **Change of licensee.** Notwithstanding any other provision of law, a change of licensee under subdivision 2 does not require the facility to meet the design requirements of section 144G.45, subdivisions 4 to 6, or 144G.81, subdivision 3.

Sec. 30. Minnesota Statutes 2020, section 144G.20, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:

(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;

(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;

(3) performs any act detrimental to the health, safety, and welfare of a resident;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the facility's residents;

(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;

(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;

(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;

(11) refuses to initiate a background study under section 144.057 or 245A.04;

(12) fails to timely pay any fines assessed by the commissioner;

(13) violates any local, city, or township ordinance relating to housing or assisted living services;

(14) has repeated incidents of personnel performing services beyond their competency level; or

(15) has operated beyond the scope of the assisted living facility's license category.

(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.

Sec. 31. Minnesota Statutes 2020, section 144G.20, subdivision 4, is amended to read:

Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 13, paragraph (a), the commissioner must revoke a license if a controlling individual of the facility is convicted of a felony or gross misdemeanor that relates to operation of the facility or directly affects resident safety or care. The commissioner shall notify the facility and the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities 30 calendar days in advance of the date of revocation.

Sec. 32. Minnesota Statutes 2020, section 144G.20, subdivision 5, is amended to read:

Subd. 5. **Owners and managerial officials; refusal to grant license.** (a) The owners and managerial officials of a facility whose Minnesota license has not been renewed or whose ~~Minnesota~~ license in this state or any other state has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment.

(b) The commissioner shall not issue a license to a facility for five years following the effective date of license nonrenewal or revocation if the owners or managerial officials, including any individual who was an owner or managerial official of another licensed provider, had a ~~Minnesota~~ license in this state or any other state that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose ~~Minnesota~~ license in this state or any other state was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the facility 30 calendar days in advance of the date of nonrenewal, suspension, or revocation of the license.

Sec. 33. Minnesota Statutes 2020, section 144G.20, subdivision 8, is amended to read:

Subd. 8. **Controlling individual restrictions.** (a) The commissioner has discretion to bar any controlling individual of a facility if the person was a controlling individual of any other nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility in the previous two-year period and:

(1) during that period of time the nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility incurred the following number of uncorrected or repeated violations:

(i) two or more repeated violations that created an imminent risk to direct resident care or safety; or

(ii) four or more uncorrected violations that created an imminent risk to direct resident care or safety; or

(2) during that period of time, was convicted of a felony or gross misdemeanor that related to the operation of the nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility, or directly affected resident safety or care.

(b) When the commissioner bars a controlling individual under this subdivision, the controlling individual may appeal the commissioner's decision under chapter 14.

Sec. 34. Minnesota Statutes 2020, section 144G.20, subdivision 9, is amended to read:

Subd. 9. **Exception to controlling individual restrictions.** Subdivision 8 does not apply to any controlling individual of the facility who had no legal authority to affect or change decisions related to the operation of the nursing home ~~or~~, assisted living facility, or home care that incurred the uncorrected or repeated violations.

Sec. 35. Minnesota Statutes 2020, section 144G.20, subdivision 12, is amended to read:

Subd. 12. **Notice to residents.** (a) Within five business days after proceedings are initiated by the commissioner to revoke or suspend a facility's license, or a decision by the commissioner not to renew a living facility's license, the controlling individual of the facility or a designee must provide to the commissioner ~~and~~, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names of residents and the names and addresses of the residents' designated representatives and legal representatives, and family or other contacts listed in the assisted living contract.

(b) The controlling individual or designees of the facility must provide updated information each month until the proceeding is concluded. If the controlling individual or designee of the facility fails to provide the information within this time, the facility is subject to the issuance of:

(1) a correction order; and

(2) a penalty assessment by the commissioner in rule.

(c) Notwithstanding subdivisions 21 and 22, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that, as of the date of the issuance of the correction order, the facility shall forfeit to the state a $500 fine the first day of noncompliance and an increase in the $500 fine by $100 increments for each day the noncompliance continues.

(d) Information provided under this subdivision may be used by the commissioner ~~or~~, the ombudsman for long-term care, or the Office of Ombudsman for Mental Health and Developmental Disabilities only for the purpose of providing affected consumers information about the status of the proceedings.

(e) Within ten business days after the commissioner initiates proceedings to revoke, suspend, or not renew a facility license, the commissioner must send a written notice of the action and the process involved to each resident of the facility, legal representatives and designated representatives, and at the commissioner's discretion, additional resident contacts.

(f) The commissioner shall provide the ombudsman for long-term care and the Office of Ombudsman for Mental Health and Developmental Disabilities with monthly information on the department's actions and the status of the proceedings.

Sec. 36. Minnesota Statutes 2020, section 144G.20, subdivision 15, is amended to read:

Subd. 15. **Plan required.** (a) The process of suspending, revoking, or refusing to renew a license must include a plan for transferring affected residents' cares to other providers by the facility. The commissioner shall monitor the transfer plan. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension, the licensee shall provide the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, ~~and~~ the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities with the following information:

(1) a list of all residents, including full names and all contact information on file;

(2) a list of the resident's legal representatives and designated representatives and family or other contacts listed in the assisted living contract, including full names and all contact information on file;

(3) the location or current residence of each resident;

(4) the payor sources for each resident, including payor source identification numbers; and

(5) for each resident, a copy of the resident's service plan and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The licensee shall cooperate with the commissioner and the lead agencies, county adult protection and case managers, ~~and~~ the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities during the process of transferring care of residents to qualified providers. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension action, the facility must notify and disclose to each of the residents, or the resident's legal and designated representatives or emergency contact persons, that the commissioner is taking action against the facility's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility does not comply with the disclosure requirements in this section, the commissioner shall notify the residents, legal and designated representatives, or emergency contact persons about the actions being taken. Lead agencies, county adult protection and case managers, and the Office of Ombudsman for Long-Term Care may also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.

(c) A facility subject to this subdivision may continue operating while residents are being transferred to other service providers.

Sec. 37. Minnesota Statutes 2020, section 144G.30, subdivision 5, is amended to read:

Subd. 5. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Sec. 38. Minnesota Statutes 2020, section 144G.31, subdivision 4, is amended to read:

Subd. 4. **Fine amounts.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in subdivisions 2 and 3 as follows and may be imposed immediately with no opportunity to correct the violation prior to imposition:

(1) Level 1, no fines or enforcement;

(2) Level 2, a fine of $500 per violation, in addition to any enforcement mechanism authorized in section 144G.20 for widespread violations;

(3) Level 3, a fine of $3,000 per violation ~~per incident~~, in addition to any enforcement mechanism authorized in section 144G.20;

(4) Level 4, a fine of $5,000 per ~~incident~~ violation, in addition to any enforcement mechanism authorized in section 144G.20; and

(5) for maltreatment violations for which the licensee was determined to be responsible for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of $1,000.

A fine of $5,000 may be imposed if the commissioner determines the licensee is responsible for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury.

(b) When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Sec. 39. Minnesota Statutes 2020, section 144G.31, subdivision 8, is amended to read:

Subd. 8. **Deposit of fines.** Fines collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner for special projects to improve ~~home care~~ resident quality of care and outcomes in assisted living facilities licensed under chapter 144G in Minnesota as recommended by the advisory council established in section 144A.4799.

EFFECTIVE DATE. This section is effective retroactively for fines collected on or after August 1, 2021.

Sec. 40. Minnesota Statutes 2020, section 144G.41, subdivision 7, is amended to read:

Subd. 7. **Resident grievances; reporting maltreatment.** All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the ~~state and applicable regional~~ Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.

Sec. 41. Minnesota Statutes 2020, section 144G.41, subdivision 8, is amended to read:

Subd. 8. **Protecting resident rights.** All facilities shall ensure that every resident has access to consumer advocacy or legal services by:

(1) providing names and contact information, including telephone numbers and e-mail addresses of at least three organizations that provide advocacy or legal services to residents, one of which must include the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities;

(2) providing the name and contact information for the Minnesota Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities~~, including both the state and regional contact information~~;

(3) assisting residents in obtaining information on whether Medicare or medical assistance under chapter 256B will pay for services;

(4) making reasonable accommodations for people who have communication disabilities and those who speak a language other than English; and

(5) providing all information and notices in plain language and in terms the residents can understand.

Sec. 42. Minnesota Statutes 2020, section 144G.42, subdivision 10, is amended to read:

Subd. 10. **Disaster planning and emergency preparedness plan.** (a) The facility must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all residents;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing ~~tenant~~ residents.

(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) The facility must meet any additional requirements adopted in rule.

Sec. 43. Minnesota Statutes 2020, section 144G.50, subdivision 2, is amended to read:

Subd. 2. **Contract information.** (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility.

(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:

(1) the facility and contracted service provider when applicable;

(2) the licensee of the facility;

(3) the managing agent of the facility, if applicable; and

(4) the authorized agent for the facility.

(c) The contract must include:

(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;

(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;

(3) a delineation of the cost and nature of any other services to be provided for an additional fee;

(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;

(5) a delineation of the grounds under which the resident may be ~~discharged, evicted, or~~ transferred or have housing or services terminated or be subject to an emergency relocation;

(6) billing and payment procedures and requirements; and

(7) disclosure of the facility's ability to provide specialized diets.

(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.

(e) The contract must include a clear and conspicuous notice of:

(1) the right under section 144G.54 to appeal the termination of an assisted living contract;

(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;

(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;

(4) the resident's right to obtain services from an unaffiliated service provider;

(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:

(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;

(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);

(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;

(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;

(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;

(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and

(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;

(6) the contact information to obtain long-term care consulting services under section 256B.0911; and

(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

Sec. 44. Minnesota Statutes 2020, section 144G.52, subdivision 2, is amended to read:

Subd. 2. **Prerequisite to termination of a contract.** (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to:

(1) explain in detail the reasons for the proposed termination; and

(2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including

but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility.

(b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.

(c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting.

(d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility ~~may attempt to schedule and participate in a meeting under this subdivision via~~ must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659.

Sec. 45. Minnesota Statutes 2020, section 144G.52, subdivision 8, is amended to read:

Subd. 8. **Content of notice of termination.** The notice required under subdivision 7 must contain, at a minimum:

(1) the effective date of the termination of the assisted living contract;

(2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;

(3) a detailed explanation of the conditions under which a new or amended contract may be executed;

(4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted;

(5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;

(6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;

(7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination;

(8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and

(9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.

Sec. 46. Minnesota Statutes 2020, section 144G.52, subdivision 9, is amended to read:

Subd. 9. **Emergency relocation.** (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.

(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:

(1) the reason for the relocation;

(2) the name and contact information for the location to which the resident has been relocated and any new service provider;

(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and

(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.

(c) The notice required under paragraph (b) must be delivered as soon as practicable to:

(1) the resident, legal representative, and designated representative;

(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and

(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.

(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

Sec. 47. Minnesota Statutes 2020, section 144G.53, is amended to read:

144G.53 NONRENEWAL OF HOUSING.

(a) If a facility decides to not renew a resident's housing under a contract, the facility must either (1) provide the resident with 60 calendar days' notice of the nonrenewal and assistance with relocation planning, or (2) follow the termination procedure under section 144G.52.

(b) The notice must include the reason for the nonrenewal and contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(c) A facility must:

(1) provide notice of the nonrenewal to the Office of Ombudsman for Long-Term Care;

(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, provide notice to the resident's case manager;

(3) ensure a coordinated move to a safe location, as defined in section 144G.55, subdivision 2, that is appropriate for the resident;

(4) ensure a coordinated move to an appropriate service provider identified by the facility, if services are still needed and desired by the resident;

(5) consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals; and

(6) prepare a written plan to prepare for the move.

(d) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may instead choose to move to

a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the nonrenewal notice.

Sec. 48. Minnesota Statutes 2020, section 144G.55, subdivision 1, is amended to read:

Subdivision 1. **Duties of facility.** (a) If a facility terminates an assisted living contract, reduces services to the extent that a resident needs to move or obtain a new service provider because of a reduction or elimination of services or the facility has its license restricted under section 144G.20, or the facility conducts a planned closure under section 144G.57, the facility:

(1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is appropriate for the resident and that is identified by the facility prior to any hearing under section 144G.54;

(2) must ensure a coordinated move of the resident to an appropriate service provider identified by the facility prior to any hearing under section 144G.54, provided services are still needed and desired by the resident; and

(3) must consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals.

(b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by moving the resident to a different location within the same facility, if appropriate for the resident.

(c) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may choose instead to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the termination notice.

(d) Sixty days before the facility plans to reduce or eliminate one or more services for a particular resident, the facility must provide written notice of the reduction or elimination that includes:

(1) a detailed explanation of the reasons for the reduction or elimination and the date of the reduction;

(2) the contact information for the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the name and contact information of the person employed by the facility with whom the resident may discuss the reduction or elimination of services;

(3) a statement that if the services being reduced or eliminated are still needed by the resident, the resident may remain in the facility and seek services from another provider; and

(4) a statement that if the reduction or elimination makes the resident need to move, the facility must participate in a coordinated move of the resident to another provider or caregiver, as required under this section.

(e) In the event of an unanticipated reduction or elimination in services caused by extraordinary circumstances, the facility must provide the notice required under paragraph (d) as soon as possible.

(f) If the facility, a resident, a legal representative, or a designated representative determines that a reduction in services will make a resident need to move to a new location, the facility must ensure a coordinated move in accordance with this section, and must provide notice to the Office of Ombudsman for Long-Term Care.

(g) Nothing in this section affects a resident's right to remain in the facility and seek services from another provider.

Sec. 49. Minnesota Statutes 2020, section 144G.55, subdivision 3, is amended to read:

Subd. 3. **Relocation plan required.** The facility must prepare a relocation plan to prepare for the move to ~~the~~ a new safe location or appropriate service provider, as required by this section.

Sec. 50. Minnesota Statutes 2020, section 144G.56, subdivision 3, is amended to read:

Subd. 3. **Notice required.** (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include:

(1) the effective date of the proposed transfer;

(2) the proposed transfer location;

(3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility;

(4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and

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

(b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to:

(1) conditions that render the resident's room or private living unit uninhabitable;

(2) the resident's urgent medical needs; or

(3) a risk to the health or safety of another resident of the facility.

Sec. 51. Minnesota Statutes 2020, section 144G.56, subdivision 5, is amended to read:

Subd. 5. **Changes in facility operations.** (a) In situations where there is a curtailment, reduction, or capital improvement within a facility necessitating transfers, the facility must:

(1) minimize the number of transfers it initiates to complete the project or change in operations;

(2) consider individual resident needs and preferences;

(3) provide reasonable accommodations for individual resident requests regarding the transfers; and

(4) in advance of any notice to any residents, legal representatives, or designated representatives, provide notice to the Office of Ombudsman for Long-Term Care and~~, when appropriate,~~ the Office of Ombudsman for Mental Health and Developmental Disabilities of the curtailment, reduction, or capital improvement and the corresponding needed transfers.

Sec. 52. Minnesota Statutes 2020, section 144G.57, subdivision 1, is amended to read:

Subdivision 1. **Closure plan required.** In the event that an assisted living facility elects to voluntarily close the facility, the facility must notify the commissioner ~~and~~, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities in writing by submitting a proposed closure plan.

Sec. 53. Minnesota Statutes 2020, section 144G.57, subdivision 3, is amended to read:

Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan shall be subject to the commissioner's approval and subdivision 6. The facility shall take no action to close the residence prior to the commissioner's approval of the plan. The

commissioner shall approve or otherwise respond to the plan ~~as soon as practicable~~ within 14 calendar days.

(b) The commissioner may require the facility to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and other professionals the commissioner deems necessary to assist in the proper relocation of residents.

Sec. 54. Minnesota Statutes 2020, section 144G.57, subdivision 5, is amended to read:

Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and legal representatives of the closure, the proposed date of closure, the contact information of the ombudsman for long-term care and the ombudsman for mental health and developmental disabilities, and that the facility will follow the termination planning requirements under section 144G.55, and final accounting and return requirements under section 144G.42, subdivision 5. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must also provide this information to the resident's case manager.

Sec. 55. Minnesota Statutes 2020, section 144G.70, subdivision 2, is amended to read:

Subd. 2. **Initial reviews, assessments, and monitoring.** (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.

(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.

(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.

(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

Sec. 56. Minnesota Statutes 2020, section 144G.70, subdivision 4, is amended to read:

Subd. 4. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(c) The facility must implement and provide all services required by the current service plan.

(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.

(e) Staff providing services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;

(2) the identification of staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring assessments of the resident;

(4) the schedule and methods of monitoring staff providing services; and

(5) a contingency plan that includes:

(i) the action to be taken if the scheduled service cannot be provided;

(ii) information and a method to contact the facility;

(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

Sec. 57. Minnesota Statutes 2020, section 144G.80, subdivision 2, is amended to read:

Subd. 2. **Demonstrated capacity.** (a) An applicant for licensure as an assisted living facility with dementia care must have the ability to provide services in a manner that is consistent with the requirements in this section. The commissioner shall consider the following criteria, including, but not limited to:

(1) the experience of the ~~applicant in~~ applicant's assisted living director, managerial official, and clinical nurse supervisor managing residents with dementia or previous long-term care experience; and

(2) the compliance history of the applicant in the operation of any care facility licensed, certified, or registered under federal or state law.

(b) If the ~~applicant does~~ applicant's assisted living director, managerial official, and clinical nurse supervisor do not have experience in managing residents with dementia, the applicant must employ a consultant for at least the first six months of operation. The consultant must meet the requirements in paragraph (a), clause (1), and make recommendations on providing dementia care services consistent with the requirements of this chapter. The consultant must (1) have two years of work experience related to dementia, health care, gerontology, or a related field, and (2) have completed at least the minimum core training requirements in section 144G.64. The applicant must document an acceptable plan to address the consultant's identified concerns and must either implement the recommendations or document in the plan any consultant recommendations that the applicant chooses not to implement. The commissioner must review the applicant's plan upon request.

(c) The commissioner shall conduct an on-site inspection prior to the issuance of an assisted living facility with dementia care license to ensure compliance with the physical environment requirements.

(d) The label "Assisted Living Facility with Dementia Care" must be identified on the license.

Sec. 58. Minnesota Statutes 2020, section 144G.90, subdivision 1, is amended to read:

Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand.

(b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse:

"If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may ~~also~~ contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

(c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.

(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

Sec. 59. Minnesota Statutes 2020, section 144G.91, subdivision 13, is amended to read:

Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or ~~where clearly inadvisable or~~ unless otherwise documented in the resident's service plan.

(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.

(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

Sec. 60. Minnesota Statutes 2020, section 144G.91, subdivision 21, is amended to read:

Subd. 21. **Access to counsel and advocacy services.** Residents have the right to the immediate access by:

(1) the resident's legal counsel;

(2) any representative of the protection and advocacy system designated by the state under Code of Federal Regulations, title 45, section 1326.21; or

(3) any representative of the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.

Sec. 61. Minnesota Statutes 2020, section 144G.91, is amended by adding a subdivision to read:

Subd. 27. **Restraints.** Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

Sec. 62. Minnesota Statutes 2020, section 144G.92, subdivision 1, is amended to read:

Subdivision 1. **Retaliation prohibited.** A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident:

(1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right;

(2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right;

(3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557;

(4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization;

(5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law;

(6) takes or indicates an intention to take civil action;

(7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding;

(8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or

(9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502.

Sec. 63. Minnesota Statutes 2020, section 144G.93, is amended to read:

144G.93 CONSUMER ADVOCACY AND LEGAL SERVICES.

Upon execution of an assisted living contract, every facility must provide the resident with the names and contact information, including telephone numbers and e-mail addresses, of:

(1) nonprofit organizations that provide advocacy or legal services to residents including but not limited to the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities; and

(2) the Office of Ombudsman for Long-Term Care~~, including both the state and regional contact information~~ and the Office of Ombudsman for Mental Health and Developmental Disabilities.

Sec. 64. Minnesota Statutes 2020, section 144G.95, is amended to read:

144G.95 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE AND OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

Subdivision 1. **Immunity from liability.** (a) The Office of Ombudsman for Long-Term Care and representatives of the office are immune from liability for conduct described in section 256.9742, subdivision 2.

(b) The Office of Ombudsman for Mental Health and Developmental Disabilities and representatives of the office are immune from liability for conduct described in section 245.96.

Subd. 2. **Data classification.** (a) All forms and notices received by the Office of Ombudsman for Long-Term Care under this chapter are classified under section 256.9744.

(b) All data collected or received by the Office of Ombudsman for Mental Health and Developmental Disabilities are classified under section 245.94.

Sec. 65. **[145.9231] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** (a) The commissioner shall establish and appoint a Health Equity Advisory and Leadership (HEAL) Council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal Government/Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

(b) No members shall be employees of the Minnesota Department of Health.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059, except that the members do not receive per diem compensation. Meetings shall be held at least quarterly and hosted by the department. Subcommittees may be developed as necessary. Advisory council meetings are subject to Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of particular agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** Notwithstanding section 15.059, subdivision 6, the advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 66. Minnesota Statutes 2020, section 146B.04, subdivision 1, is amended to read:

Subdivision 1. **General.** Before an individual may work as a guest artist, the commissioner shall issue a temporary license to the guest artist. The guest artist shall submit an application to the commissioner on a form provided by the commissioner. The commissioner must receive the application at least 14 calendar days before the guest artist applicant conducts a body art procedure. The form must include:

(1) the name, home address, and date of birth of the guest artist;

(2) the name of the licensed technician sponsoring the guest artist;

(3) proof of having satisfactorily completed coursework within the year preceding application and approved by the commissioner on bloodborne pathogens, the prevention of disease transmission, infection control, and aseptic technique;

(4) the starting and anticipated completion dates the guest artist will be working; and

(5) a copy of any current body art credential or licensure issued by another local or state jurisdiction.

Sec. 67. Minnesota Statutes 2020, section 152.22, subdivision 8, is amended to read:

Subd. 8. **Medical cannabis ~~product~~ paraphernalia.** "Medical cannabis ~~product~~ paraphernalia" means any delivery device or related supplies and educational materials used in the administration of medical cannabis for a patient with a qualifying medical condition enrolled in the registry program.

Sec. 68. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner shall register two in-state manufacturers for the production of all medical cannabis within the state. A registration agreement between the commissioner and a manufacturer is nontransferable. The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in this subdivision. The commissioner shall accept applications after December 1, 2014, if one of the manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer. The commissioner's determination that no manufacturer exists to fulfill the duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court. Data submitted during the application process are private data on individuals or nonpublic data as defined in section 13.02 until the manufacturer is registered under this section. Data on a manufacturer that is registered are public data, unless the data are trade secret or security information under section 13.37.

(b) As a condition for registration, a manufacturer must agree to:

(1) begin supplying medical cannabis to patients ~~by July 1, 2015~~ within eight months of its initial registration; and

(2) comply with all requirements under sections 152.22 to 152.37.

(c) The commissioner shall consider the following factors when determining which manufacturer to register:

(1) the technical expertise of the manufacturer in cultivating medical cannabis and converting the medical cannabis into an acceptable delivery method under section 152.22, subdivision 6;

(2) the qualifications of the manufacturer's employees;

(3) the long-term financial stability of the manufacturer;

(4) the ability to provide appropriate security measures on the premises of the manufacturer;

(5) whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by sections 152.22 to 152.37; and

(6) the manufacturer's projection and ongoing assessment of fees on patients with a qualifying medical condition.

(d) If an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law under section 152.33, subdivision 1, the commissioner may decide not to renew the registration of the manufacturer, provided the violation occurred while the person was an officer, director, or controlling person of the manufacturer.

(e) The commissioner shall require each medical cannabis manufacturer to contract with an independent laboratory to test medical cannabis produced by the manufacturer. The commissioner shall approve the laboratory chosen by each manufacturer and require that the laboratory report testing results to the manufacturer in a manner determined by the commissioner.

(f) The commissioner shall implement a state-centralized medical cannabis electronic database to monitor and track the manufacturers' medical cannabis inventories from the seed or clone source through cultivation, processing, testing, and distribution or disposal. The inventory tracking database must allow for information regarding medical cannabis to be updated instantaneously. Any manufacturer or third-party laboratory licensed under this chapter must submit to the commissioner any information the commissioner deems necessary for maintaining the inventory tracking database. The commissioner may contract with a separate entity to establish and maintain all or any part of the inventory tracking database. The provisions of section 13.05, subdivision 11, apply to a contract entered between the commissioner and a third party under this paragraph.

Sec. 69. Minnesota Statutes 2021 Supplement, section 152.27, subdivision 2, is amended to read:

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

(4) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition ~~and include in the certification an option for the practitioner to certify whether the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility~~;

(5) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

(6) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

(7) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) The commissioner may add a delivery method under section 152.22, subdivision 6, or add, remove, or modify a qualifying medical condition under section 152.22, subdivision 14, upon a petition from a member of the public or the task force on medical cannabis therapeutic research or as directed by law. The commissioner shall evaluate all petitions to add a qualifying medical condition or to remove or modify an existing qualifying medical condition submitted by the task force on medical cannabis therapeutic research or as directed by law and may make the addition, removal, or modification if the commissioner determines the addition, removal, or modification is warranted based on the best available evidence and research. If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or add or remove a qualifying medical condition under section 152.22,

subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition or removal and the reasons for its addition or removal, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Sec. 70. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 1, is amended to read:

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

(b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may acquire hemp products produced by a hemp processor. A manufacturer may manufacture or process hemp and hemp products into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under this paragraph are subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

(c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp or hemp products acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The laboratory must collect, or contract with a third party that is not a manufacturer to collect, from the manufacturer's production facility the medical cannabis samples it will test. The cost of collecting samples and laboratory testing shall be paid by the manufacturer.

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

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

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

(3) procedures for the delivery and transportation of hemp between hemp growers and manufacturers and for the delivery and transportation of hemp products between hemp processors and manufacturers.

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

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

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

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

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

(j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the

manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

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

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

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

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

(1) business operations;

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

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

(4) physical and electronic security alarm systems.

Sec. 71. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis ~~products~~ paraphernalia that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may distribute medical cannabis ~~products~~ paraphernalia, whether or not the ~~products~~ medical cannabis paraphernalia have been manufactured by that manufacturer.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely by secure videoconference, telephone, or other remote means, so long as the employee providing the consultation is able to confirm the identity of the patient and the consultation adheres to patient privacy requirements that apply to health care services delivered through telehealth. A pharmacist consultation under this clause is not required when a manufacturer is distributing medical cannabis to a patient according to a patient-specific dosage plan established with that manufacturer and is not modifying the dosage or product being distributed under that plan and the medical cannabis is distributed by a pharmacy technician;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis ~~products~~ paraphernalia to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

(e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian, or spouse of a patient age 21 or older.

Sec. 72. Minnesota Statutes 2020, section 152.29, subdivision 3a, is amended to read:

Subd. 3a. **Transportation of medical cannabis; transport staffing.** (a) A medical cannabis manufacturer may staff a transport motor vehicle with only one employee if the medical cannabis manufacturer is transporting medical cannabis to ~~either a certified laboratory for the purpose of testing or~~ a facility for the purpose of disposal. If the medical cannabis manufacturer is transporting medical cannabis for any other purpose or destination, the transport motor vehicle must be staffed with a minimum of two employees as required by rules adopted by the commissioner.

(b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only transporting hemp for any purpose may staff the transport motor vehicle with only one employee.

(c) A medical cannabis manufacturer may contract with a third party for armored car services for deliveries of medical cannabis from its production facility to distribution facilities. A medical cannabis manufacturer that contracts for armored car services remains responsible for compliance with transportation manifest and inventory tracking requirements in rules adopted by the commissioner.

(d) A third-party testing laboratory may staff a transport motor vehicle with one or more employees when transporting medical cannabis from a manufacturer's production facility to the testing laboratory for the purpose of testing samples.

(e) Department of Health staff may transport medical cannabis for the purposes of delivering medical cannabis and other samples to a laboratory for testing under rules adopted by the commissioner and in cases of special investigations when the commissioner has determined there is a potential threat to public health. The transport motor vehicle must be

staffed by a minimum of two Department of Health employees. The employees must carry their Department of Health identification cards and a transport manifest that meets the requirements in Minnesota Rules, part 4770.1100, subpart 2.

(f) A Tribal medical cannabis program operated by a federally recognized Indian Tribe located within the state of Minnesota may transport samples of medical cannabis to testing laboratories in the state. Transport vehicles must be staffed by at least two employees of the Tribal medical cannabis program. Transporters must carry identification identifying them as employees of the Tribal medical cannabis program and a detailed transportation manifest that includes the place and time of departure, the address of the testing laboratory destination, and a description and count of the medical cannabis being transported.

Sec. 73. Minnesota Statutes 2020, section 152.30, is amended to read:

152.30 PATIENT DUTIES.

(a) A patient shall apply to the commissioner for enrollment in the registry program by submitting an application as required in section 152.27 and an annual registration fee as determined under section 152.35.

(b) As a condition of continued enrollment, patients shall agree to:

(1) continue to receive regularly scheduled treatment for their qualifying medical condition from their health care practitioner; and

(2) report changes in their qualifying medical condition to their health care practitioner.

(c) A patient shall only receive medical cannabis from a registered manufacturer but is not required to receive medical cannabis ~~products~~ paraphernalia from only a registered manufacturer.

Sec. 74. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis ~~products~~ paraphernalia by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

Sec. 75. Minnesota Statutes 2020, section 152.36, is amended to read:

152.36 IMPACT ASSESSMENT OF MEDICAL CANNABIS THERAPEUTIC RESEARCH.

Subdivision 1. **Task force on medical cannabis therapeutic research.** (a) A 23-member task force on medical cannabis therapeutic research is created to conduct an impact assessment of medical cannabis therapeutic research. The task force shall consist of the following members:

(1) two members of the house of representatives, one selected by the speaker of the house, the other selected by the minority leader;

(2) two members of the senate, one selected by the majority leader, the other selected by the minority leader;

(3) four members representing consumers or patients enrolled in the registry program, including at least two parents of patients under age 18;

(4) four members representing health care providers, including one licensed pharmacist;

(5) four members representing law enforcement, one from the Minnesota Chiefs of Police Association, one from the Minnesota Sheriff's Association, one from the Minnesota Police and Peace Officers Association, and one from the Minnesota County Attorneys Association;

(6) four members representing substance use disorder treatment providers; and

(7) the commissioners of health, human services, and public safety.

(b) Task force members listed under paragraph (a), clauses (3), (4), (5), and (6), shall be appointed by the governor under the appointment process in section 15.0597. Members shall serve on the task force at the pleasure of the appointing authority. ~~All members must~~

~~be appointed by July 15, 2014, and the commissioner of health shall convene the first meeting of the task force by August 1, 2014.~~

(c) There shall be two cochairs of the task force chosen from the members listed under paragraph (a). One cochair shall be selected by the speaker of the house and the other cochair shall be selected by the majority leader of the senate. The authority to convene meetings shall alternate between the cochairs.

(d) Members of the task force other than those in paragraph (a), clauses (1), (2), and (7), shall receive expenses as provided in section 15.059, subdivision 6.

Subd. 1a. **Administration.** The commissioner of health shall provide administrative and technical support to the task force.

Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact of the use of medical cannabis and hemp and Minnesota's activities involving medical cannabis and hemp, including, but not limited to:

(1) program design and implementation;

(2) the impact on the health care provider community;

(3) patient experiences;

(4) the impact on the incidence of substance abuse;

(5) access to and quality of medical cannabis, hemp, and medical cannabis ~~products~~ paraphernalia;

(6) the impact on law enforcement and prosecutions;

(7) public awareness and perception; and

(8) any unintended consequences.

~~Subd. 3. **Cost assessment.** By January 15 of each year, beginning January 15, 2015, and ending January 15, 2019, the commissioners of state departments impacted by the medical cannabis therapeutic research study shall report to the cochairs of the task force on the costs incurred by each department on implementing sections 152.22 to 152.37. The reports must compare actual costs to the estimated costs of implementing these sections and must be submitted to the task force on medical cannabis therapeutic research.~~

Subd. 4. **Reports to the legislature.** (a) The cochairs of the task force shall submit ~~the following reports~~ an impact assessment report to the chairs and ranking minority members

of the legislative committees and divisions with jurisdiction over health and human services, public safety, judiciary, and civil law~~:~~

~~(1)~~ by February 1, 2015, ~~a report on the design and implementation of the registry program;~~ and every two years thereafter~~, a complete impact assessment report; and~~.

~~(2) upon receipt of a cost assessment from a commissioner of a state agency, the completed cost assessment.~~

(b) The task force may make recommendations to the legislature on whether to add or remove conditions from the list of qualifying medical conditions.

Subd. 5. **No expiration.** The task force on medical cannabis therapeutic research does not expire.

Sec. 76. **COMMISSIONER OF HEALTH; RECOMMENDATION REGARDING EXCEPTION TO HOSPITAL CONSTRUCTION MORATORIUM.**

By February 1, 2023, the commissioner of health, in consultation with the commissioner of human services, shall make a recommendation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance as to whether Minnesota Statutes, section 144.551, subdivision 1, should be amended to authorize exceptions, for hospitals in other counties and without a public interest review, that are substantially similar to the exception in Minnesota Statutes, section 144.551, subdivision 1, paragraph (b), clause (31).

Sec. 77. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer reporting system" wherever it appears in Minnesota Statutes and Minnesota Rules.

(b) The revisor of statutes shall make any necessary cross-reference changes required as a result of the amendments in sections 17 to 22.

ARTICLE 3
HEALTH CARE FINANCE

Section 1. **[62J.86] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability Advisory Council established under section 62J.88.

Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under section 62J.87.

Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

Subdivision 1. **Establishment.** The Health Care Affordability Board is established and shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. The board must be operational by January 1, 2023.

Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members, appointed as follows:

(1) five members appointed by the governor;

(2) two members appointed by the majority leader of the senate;

(3) two members appointed by the minority leader of the senate;

(4) two members appointed by the speaker of the house; and

(5) two members appointed by the minority leader of the house of representatives.

(b) All appointed members must have knowledge and demonstrated expertise in one or more of the following areas: health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, purchasing health care insurance as a health benefits administrator, delivery of primary care, health plan company administration, public or population health, and addressing health disparities and structural inequities.

(c) A member may not participate in board proceedings involving an organization, activity, or transaction in which the member has either a direct or indirect financial interest, other than as an individual consumer of health services.

(d) The Legislative Coordinating Commission shall coordinate appointments under this subdivision to ensure that board members are appointed by August 1, 2022, and that board members as a whole meet all of the criteria related to the knowledge and expertise specified in paragraph (b).

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall not serve more than three consecutive terms.

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for two years.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time executive director and other staff, who shall serve in the unclassified service. The executive director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

(b) The attorney general shall provide legal services to the board.

(c) The Health Economics Program within the Department of Health shall provide technical assistance to the board in analyzing health care trends and costs and in setting health care spending growth targets.

(d) The board may employ or contract for professional and technical assistance, including actuarial assistance, as the board deems necessary to perform the board's duties.

Subd. 6. **Access to information.** (a) The board may request that a state agency provide the board with any publicly available information in a usable format as requested by the board, at no cost to the board.

(b) The board may request from a state agency unique or custom data sets, and the agency may charge the board for providing the data at the same rate the agency would charge any other public or private entity.

(c) Any information provided to the board by a state agency must be de-identified. For purposes of this subdivision, "de-identification" means the process used to prevent the identity of a person or business from being connected with the information and ensuring all identifiable information has been removed.

(d) Any data submitted to the board retains its original classification under the Minnesota Data Practices Act in chapter 13.

Subd. 7. **Compensation.** Board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least quarterly. The board may meet in closed session when reviewing proprietary information as specified in section 62J.71, subdivision 4.

(b) The board shall announce each public meeting at least two weeks prior to the scheduled date of the meeting. Any materials for the meeting must be made public at least one week prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability Advisory Council of up to 15 members to provide advice to the board on health care costs and access issues and to represent the views of patients and other stakeholders. Members of the advisory council must be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: health care delivery, ensuring health care access for diverse populations, public and population health, patient perspectives, health care cost trends and drivers, clinical and health services research, innovation in health care delivery, and health care benefits management.

Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to the board on:

(1) the identification of economic indicators and other metrics related to the development and setting of health care spending growth targets;

(2) data sources for measuring health care spending; and

(3) measurement of the impact of health care spending growth targets on diverse communities and populations, including but not limited to those communities and populations adversely affected by health disparities.

(b) The council shall report technical recommendations and a summary of its activities to the board at least annually, and shall submit additional reports on its activities and recommendations to the board, as requested by the board or at the discretion of the council.

Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, advisory council members shall serve four-year terms.

(b) Removal and vacancies of advisory council members are governed by section 15.059.

Subd. 4. **Compensation.** Advisory council members may be compensated according to section 15.059.

Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the advisory council are subject to chapter 13D.

Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

Subdivision 1. **General.** (a) The board shall monitor the administration and reform of the health care delivery and payment systems in the state. The board shall:

(1) set health care spending growth targets for the state, as specified under section 62J.90;

(2) enhance the transparency of provider organizations;

(3) monitor the adoption and effectiveness of alternative payment methodologies;

(4) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care;

(5) monitor and review the impact of changes within the health care marketplace; and

(6) monitor patient access to necessary health care services.

(b) The board shall establish goals to reduce health care disparities in racial and ethnic communities and to ensure access to quality care for persons with disabilities or with chronic or complex health conditions.

Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the commercial health insurance market, including large self-insured employers and the state's public health care programs, in order to identify opportunities for state action to achieve:

(1) improved patient experience of care, including quality and satisfaction;

(2) improved health of all populations, including a reduction in health disparities; and

(3) a reduction in the growth of health care costs.

Subd. 3. **Recommendations for reform.** The board shall recommend legislative policy, market, or any other reforms to:

(1) lower the rate of growth in commercial health care costs and public health care program spending in the state;

(2) positively impact the state's rankings in the areas listed in this subdivision and subdivision 2; and

(3) improve the quality and value of care for all Minnesotans, and for specific populations adversely affected by health inequities.

Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient Protection, to be operational by January 1, 2024. The office shall assist consumers with issues related to access and quality of health care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experiences by reducing complexity for consumers.

Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

Subdivision 1. **Establishment and administration.** The board shall establish and administer the health care spending growth target program to limit health care spending growth in the state, and shall report regularly to the legislature and the public on progress toward these targets.

Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels.

(b) The health care spending growth target must:

(1) use a clear and operational definition of total state health care spending;

(2) promote a predictable and sustainable rate of growth for total health care spending as measured by an established economic indicator, such as the rate of increase of the state's economy or of the personal income of residents of this state, or a combination;

(3) define the health care markets and the entities to which the targets apply;

(4) take into consideration the potential for variability in targets across public and private payers;

(5) account for the health status of patients; and

(6) incorporate specific benchmarks related to health equity.

(c) In developing, implementing, and evaluating the growth target program, the board shall:

(1) consider the incorporation of quality of care and primary care spending goals;

(2) ensure that the program does not place a disproportionate burden on communities most impacted by health disparities, the providers who primarily serve communities most impacted by health disparities, or individuals who reside in rural areas or have high health care needs;

(3) explicitly consider payment models that help ensure financial sustainability of rural health care delivery systems and the ability to provide population health;

(4) allow setting growth targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating:

(i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

(ii) an equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix;

(5) ensure that growth targets:

(i) do not constrain the Minnesota health care workforce, including the need to provide competitive wages and benefits;

(ii) do not limit the use of collective bargaining or place a floor or ceiling on health care workforce compensation; and

(iii) promote workforce stability and maintain high-quality health care jobs; and

(6) consult with the advisory council and other stakeholders.

Subd. 3. **Data.** The board shall identify data to be used for tracking performance in meeting the growth target and identify methods of data collection necessary for efficient implementation by the board. In identifying data and methods, the board shall:

(1) consider the availability, timeliness, quality, and usefulness of existing data, including the data collected under section 62U.04;

(2) assess the need for additional investments in data collection, data validation, or data analysis capacity to support the board in performing its duties; and

(3) minimize the reporting burden to the extent possible.

Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2023, and by June 15 of each succeeding calendar year through June 15, 2027, shall establish annual

health care spending growth targets for the next calendar year consistent with the requirements of this section. The board shall set annual health care spending growth targets for the five-year period from January 1, 2024, through December 31, 2028.

(b) The board shall periodically review all components of the health care spending growth target program methodology, economic indicators, and other factors. The board may revise the annual spending growth targets after a public hearing, as appropriate. If the board revises a spending growth target, the board must provide public notice at least 60 days before the start of the calendar year to which the revised growth target will apply.

(c) The board, based on an analysis of drivers of health care spending and evidence from public testimony, shall evaluate strategies and new policies, including the establishment of accountability mechanisms, that are able to contribute to meeting growth targets and limiting health care spending growth without increasing disparities in access to health care.

Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present findings from spending growth target monitoring. The board shall also regularly hold public hearings to take testimony from stakeholders on health care spending growth, setting and revising health care spending growth targets, the impact of spending growth and growth targets on health care access and quality, and as needed to perform the duties assigned under section 62J.89, subdivisions 1, 2, and 3.

Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that have been identified by the board as exceeding the spending growth target for any given year.

(b) For purposes of this section, "health care entity" must be defined by the board during the development of the health care spending growth methodology. When developing this methodology, the board shall consider a definition of health care entity that includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, and other entities defined by the board, provided that physician organizations with a patient panel of 15,000 or fewer, or which represent providers who collectively receive less than $25,000,000 in annual net patient service revenue from health plan companies and other payers, are exempt.

Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement procedures to assist health care entities to improve efficiency and reduce cost growth by requiring some or all health care entities provided notice under subdivision 1 to file and

implement a performance improvement plan. The board shall provide written notice of this requirement to health care entities.

(b) Within 45 days of receiving a notice of the requirement to file a performance improvement plan, a health care entity shall:

(1) file a performance improvement plan with the board; or

(2) file an application with the board to waive the requirement to file a performance improvement plan or extend the timeline for filing a performance improvement plan.

(c) The health care entity may file any documentation or supporting evidence with the board to support the health care entity's application to waive or extend the timeline to file a performance improvement plan. The board shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application, provided that this information must be made public at the discretion of the board. The board may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price, and utilization trends of the health care entity over time, and any demonstrated improvement in reducing per capita medical expenses adjusted by health status;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. These factors may include but are not limited to age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity; and

(5) any other factors the board considers relevant. If the board declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the board shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(d) A health care entity shall file a performance improvement plan with the board:

(1) within 45 days of receipt of an initial notice;

(2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or

(3) if the health care entity is granted an extension, on the date given on the extension.

(e) The performance improvement plan must identify the causes of the entity's cost growth and include but not be limited to specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan must include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan must not exceed 18 months.

(f) The board shall approve any performance improvement plan it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation. If the board determines that the performance improvement plan is unacceptable or incomplete, the board may provide consultation on the criteria that have not been met and may allow an additional time period of up to 30 calendar days for resubmission. Upon approval of the proposed performance improvement plan, the board shall notify the health care entity to begin immediate implementation of the performance improvement plan. The board shall provide public notice on its website identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the board. The board shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(g) All health care entities shall in good faith work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan, the health care entity may file amendments to the performance improvement plan, subject to approval of the board. At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the board regarding the outcome of the performance improvement plan. If the board determines the performance improvement plan was not implemented successfully, the board shall:

(1) extend the implementation timetable of the existing performance improvement plan;

(2) approve amendments to the performance improvement plan as proposed by the health care entity;

(3) require the health care entity to submit a new performance improvement plan; or

(4) waive or delay the requirement to file any additional performance improvement plans.

(h) Upon the successful completion of the performance improvement plan, the board shall remove the identity of the health care entity from the board's website. The board may assist health care entities with implementing the performance improvement plans or otherwise ensure compliance with this subdivision.

(i) If the board determines that a health care entity has:

(1) willfully neglected to file a performance improvement plan with the board within 45 days as required;

(2) failed to file an acceptable performance improvement plan in good faith with the board;

(3) failed to implement the performance improvement plan in good faith; or

(4) knowingly failed to provide information required by this subdivision to the board or knowingly provided false information, the board may assess a civil penalty to the health care entity of not more than $500,000. The board must only impose a civil penalty as a last resort.

Sec. 7. **[62J.92] REPORTING REQUIREMENTS.**

Subdivision 1. **General requirement.** (a) The board shall present the reports required by this section to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy. The board shall also make these reports available to the public on the board's website.

(b) The board may contract with a third-party vendor for technical assistance in preparing the reports.

Subd. 2. **Progress reports.** The board shall submit written progress updates about the development and implementation of the health care spending growth target program by February 15, 2024, and February 15, 2025. The updates must include reporting on board membership and activities, program design decisions, planned timelines for implementation of the program, and the progress of implementation. The reports must include the methodological details underlying program design decisions.

Subd. 3. **Health care spending trends.** By December 15, 2024, and every December 15 thereafter, the board shall submit a report on health care spending trends and the health care spending growth target program that includes:

(1) spending growth in aggregate and for entities subject to health care spending growth targets relative to established target levels;

(2) findings from analyses of drivers of health care spending growth;

(3) estimates of the impact of health care spending growth on Minnesota residents, including for communities most impacted by health disparities, related to their access to insurance and care, value of health care, and the ability to pursue other spending priorities;

(4) the potential and observed impact of the health care growth targets on the financial viability of the rural delivery system;

(5) changes under consideration for revising the methodology to monitor or set growth targets;

(6) recommendations for initiatives to assist health care entities in meeting health care spending growth targets, including broader and more transparent adoption of value-based payment arrangements; and

(7) the number of health care entities whose spending growth exceeded growth targets, information on performance improvement plans and the extent to which the plans were completed, and any civil penalties imposed on health care entities related to noncompliance with performance improvement plans and related requirements.

Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

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

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

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

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

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

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

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

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

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

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

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

(6) to provide technical assistance to the Health Care Affordability Board to implement sections 62J.86 to 62J.92.

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

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

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

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

Sec. 9. Minnesota Statutes 2020, section 256B.021, subdivision 4, is amended to read:

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives ~~through Medicaid and MinnesotaCare enrollee cost-sharing and other means~~ to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 10. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, is amended to read:

Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that includes the percentage for adults and children one through 20 years of age for the most recent complete calendar year receiving at least one dental visit for both fee-for-service and the prepaid medical assistance program. The report must include:

(1) statewide utilization for both fee-for-service and for the prepaid medical assistance program;

(2) utilization by county;

(3) utilization by children receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan;

(4) utilization by adults receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan.

(b) The report must also include a description of any corrective action plans required to be submitted under subdivision 2.

(c) The initial report due on March 15, 2022, must include the utilization metrics described in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

(d) In the annual report due on March 15, 2023, and in each report due thereafter, the commissioner shall include the following:

(1) the number of dentists enrolled with the commissioner as a medical assistance dental provider and the county or counties in which the dentist provides services;

(2) the number of enrolled dentists who provided fee-for-service dental services to medical assistance or MinnesotaCare patients within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients;

(3) the number of enrolled dentists who provided dental services to medical assistance or MinnesotaCare patients through a managed care plan or county-based purchasing plan within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients; and

(4) the number of dentists who provided dental services to a new patient who was enrolled in medical assistance or MinnesotaCare within the previous calendar year.

(e) The report due on March 15, 2023, must include the metrics described in paragraph (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

Sec. 11. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes ~~and recipient cost-sharing~~ under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 12. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; ~~and~~

(6) drugs~~.~~; and

(7) quitline services as described in section 256B.0625, subdivision 68.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

Sec. 13. Minnesota Statutes 2020, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age or older, and who was enrolled in medical assistance under ~~the~~ a state plan or a waiver of ~~the~~ a plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning January 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care and enrolled in another state's Medicaid program while in foster care, in accordance with Public Law 115-271, section 1002, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 14. Minnesota Statutes 2020, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person and the person's spouse in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; ~~and~~

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.; and

(8) for individuals who were enrolled in medical assistance during the COVID-19 federal public health emergency declared by the United States Secretary of Health and Human Services and who are subject to the asset limits established by this subdivision, assets in excess of the limits must be disregarded until 95 days after the individual's first renewal occurring after the expiration of the COVID-19 federal public health emergency declared by the United States Secretary of Health and Human Services.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to ~~100~~ ..... percent of the federal poverty guidelines effective July 1, 2024, and up to 133 percent of the federal poverty guidelines effective July 1, 2025. Effective January 1, 2000, and each successive January, recipients of Supplemental Security Income may have an income up to the Supplemental Security Income standard in effect on that date.

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

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

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

(e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child under age 19 may have income up to 275 percent of the federal poverty guidelines for the household size.

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

Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 7, is amended to read:

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

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

(c) Once determined eligible for medical assistance, a child under the age of 21 is continuously eligible for a period of up to 12 months, unless:

(1) the child reaches age 21;

(2) the child requests voluntary termination of coverage;

(3) the child ceases to be a resident of Minnesota;

(4) the child dies; or

(5) the agency determines the child's eligibility was erroneously granted due to agency error or enrollee fraud, abuse, or perjury.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental services.

~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:~~

~~(1) comprehensive exams, limited to once every five years;~~

~~(2) periodic exams, limited to one per year;~~

~~(3) limited exams;~~

~~(4) bitewing x-rays, limited to one per year;~~

~~(5) periapical x-rays;~~

~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;~~

~~(7) prophylaxis, limited to one per year;~~

~~(8) application of fluoride varnish, limited to one per year;~~

~~(9) posterior fillings, all at the amalgam rate;~~

~~(10) anterior fillings;~~

~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

~~(12) removable prostheses, each dental arch limited to one every six years;~~

~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

~~(14) palliative treatment and sedative fillings for relief of pain;~~

~~(15) full-mouth debridement, limited to one every five years; and~~

~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.~~

~~(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:~~

~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~

~~(2) general anesthesia; and~~

~~(3) full-mouth survey once every five years.~~

~~(d) Medical assistance covers medically necessary dental services for children and pregnant women.~~ The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar ~~for children only~~;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

~~(c)~~ (b) In addition to the services specified in ~~paragraphs (b) and (c)~~ paragraph (a), medical assistance covers the following services ~~for adults~~:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

~~(f)~~ (c) The commissioner shall not require prior authorization for the services included in paragraph ~~(c)~~ (b), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph ~~(c)~~ (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Sec. 18. 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, 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).

(r) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision.

Sec. 21. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is for recipients age 21 or under who elect to receive hospice care delivered in a facility that is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility under section 144A.75, subdivision 13, paragraph (a). Hospice care services under subdivision 22 are not hospice respite or end-of-life care under this subdivision.

(b) The payment rates for coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services as published in the Centers for Medicare and Medicaid Services annual final rule updating payments and policies for hospice care. Payment for hospice respite and end-of-life care under this subdivision must be made from state funds, though the commissioner shall seek to obtain federal financial participation for the payments. Payment for hospice respite and end-of-life care must be paid to the residential hospice facility and are not included in any limits or cap amount applicable to hospice services payments to the elected hospice services provider.

(c) Certification of the residential hospice facility by the federal Medicare program must not be a requirement of medical assistance payment for hospice respite and end-of-life care under this subdivision.

Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas in order to provide direct reimbursement.

EFFECTIVE DATE. This section is effective January 1, 2024, subject to federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to

organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the

date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2022, an enrolled Indian Health Service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. No requirements that otherwise apply to FQHCs covered in this subdivision apply to Tribal FQHCs enrolled under this paragraph, except those necessary to comply with federal regulations. The commissioner shall establish an alternative payment method for Tribal FQHCs enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

Sec. 24. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) "Durable medical equipment" means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat the recipient's health condition that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration approved monitoring device and any related service or subscription supporting the prescribed use of the device, including technology that:

(1) provides ongoing patient monitoring and alert services that detects nocturnal seizure activity and transmits notification of the seizure activity to a caregiver for appropriate medical response; or

(2) collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 25. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine products. Medical assistance must cover services and drugs as provided in this subdivision consistent with evidence-based or evidence-informed best practices.

(b) Medical assistance must cover in-person individual and group tobacco and nicotine cessation education and counseling services if provided by a health care practitioner whose scope of practice encompasses tobacco and nicotine cessation education and counseling. Service providers include but are not limited to the following:

(1) mental health practitioners under section 245.462, subdivision 17;

(2) mental health professionals under section 245.462, subdivision 18;

(3) mental health certified peer specialists under section 256B.0615;

(4) alcohol and drug counselors licensed under chapter 148F;

(5) recovery peers as defined in section 245F.02, subdivision 21;

(6) certified tobacco treatment specialists;

(7) community health workers;

(8) physicians;

(9) physician assistants;

(10) advanced practice registered nurses; or

(11) other licensed or nonlicensed professionals or paraprofessionals with training in providing tobacco and nicotine cessation education and counseling services.

(c) Medical assistance covers telephone cessation counseling services provided through a quitline. Notwithstanding subdivision 3b, quitline services may be provided through audio-only communications. The commissioner may use volume purchasing for quitline services consistent with section 256B.04, subdivision 14.

(d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy drugs approved by the United States Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a Medicaid drug rebate agreement.

(e) Services covered under this subdivision may be provided by telemedicine.

(f) The commissioner must not:

(1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation services;

(2) prohibit the simultaneous use of multiple cessation services, including but not limited to simultaneous use of counseling and drugs;

(3) require counseling prior to receiving drugs or as a condition of receiving drugs;

(4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of a medically accepted indication, as defined in United States Code, title 42, section 1396r-8(k)(6); limit dosing frequency; or impose duration limits;

(5) prohibit simultaneous use of multiple drugs, including prescription and over-the-counter drugs;

(6) require or authorize step therapy; or

(7) require or utilize prior authorization or require a co-payment or deductible for any tobacco and nicotine cessation services and drugs covered under this subdivision.

(g) The commissioner must require all participating entities under contract with the commissioner to comply with this subdivision when providing coverage, services, or care management for medical assistance and MinnesotaCare enrollees. For purposes of this subdivision, "participating entity" means any of the following:

(1) a health carrier as defined in section 62A.011, subdivision 2;

(2) a county-based purchasing plan established under section 256B.692;

(3) an accountable care organization or other entity participating as an integrated health partnership under section 256B.0755;

(4) an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756;

(5) a network of health care providers established to offer services under medical assistance or MinnesotaCare; or

(6) any other entity that has a contract with the commissioner to cover, provide, or manage health care services provided to medical assistance or MinnesotaCare enrollees on a capitated or risk-based payment arrangement or under a reimbursement methodology with substantial financial incentives to reduce the total cost of health care for a population of patients that is enrolled with or assigned or attributed to the entity.

Sec. 26. Minnesota Statutes 2020, section 256B.0631, as amended by Laws 2021, First Special Session chapter 7, article 1, section 17, is amended to read:

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011, through December 31, 2022:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care

plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

(f) Paragraphs (a) to (e) apply only for services provided through December 31, 2022. Effective for services provided on or after January 1, 2023, the medical assistance program shall not require deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject, through December 31, 2022, to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

(d) Paragraphs (a) to (c) apply only for services provided through December 31, 2022.

Sec. 27. Minnesota Statutes 2021 Supplement, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan ~~shall~~ must include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b) and except that a co-payment must not apply to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant,

chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. ~~No~~ Co-payments ~~shall~~ must not apply to antipsychotic drugs when used for the treatment of mental illness. Co-payments must not apply to drugs when used for tobacco and nicotine cessation;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible ~~shall~~ must not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans ~~shall~~ must certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive

co-payments. The value of the co-payments ~~shall~~ must not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Sec. 28. Minnesota Statutes 2020, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties, but shall provide all eligible individuals the opportunity to opt out of enrollment in managed care under this section. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10;

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require, subject to the opt-out provision under paragraph (a), those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and given the opportunity to opt out of managed care enrollment. After notification, those individuals who choose not to opt out shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled

in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 29. Minnesota Statutes 2020, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund ~~$23,936,000 in fiscal years 2012 and 2013 and~~ $49,552,000 in fiscal year 2014 and thereafter.

(e) If the federal waiver described in paragraph (b) is not renewed, the transfer described in paragraph (c) and corresponding payments under section 62J.692, subdivision 7, are terminated effective the first month in which the waiver is no longer in effect, and the state share of the amount described in paragraph (d) must be transferred to the medical education and research fund and distributed according to the provisions of section 62J.692, subdivision 4a.

Sec. 30. Minnesota Statutes 2020, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 31. Minnesota Statutes 2020, section 256B.69, subdivision 36, is amended to read:

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan or opting out of managed care;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 32. Minnesota Statutes 2020, section 256B.692, subdivision 1, is amended to read:

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69, subject to the opt-out provision of section 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 33. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

Subdivision 1. **Information provided by commissioner.** The commissioner shall provide to each potential enrollee the following information:

(1) basic features of receiving services through managed care;

(2) which individuals are excluded from managed care enrollment, subject to ~~mandatory managed care enrollment~~ the opt-out provision of section 256B.69, subdivision 4, paragraph (a), or who may choose to enroll voluntarily;

(3) ~~for mandatory and voluntary enrollment,~~ the length of the enrollment period and information about an enrollee's right to disenroll in accordance with Code of Federal Regulations, part 42, section 438.56;

(4) the service area covered by each managed care organization;

(5) covered services, including services provided by the managed care organization and services provided by the commissioner;

(6) the provider directory and drug formulary for each managed care organization;

(7) cost-sharing requirements;

(8) requirements for adequate access to services, including provider network adequacy standards;

(9) a managed care organization's responsibility for coordination of enrollee care; and

(10) quality and performance indicators, including enrollee satisfaction for each managed care organization, if available.

Sec. 34. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

Subdivision 1. **Information provided by commissioner.** The commissioner shall provide to each potential enrollee the following information:

(1) basic features of receiving services through managed care;

(2) which individuals are excluded from managed care enrollment, subject to mandatory managed care enrollment, or who may choose to enroll voluntarily;

(3) for mandatory and voluntary enrollment, the length of the enrollment period and information about an enrollee's right to disenroll in accordance with Code of Federal Regulations, part 42, section 438.56;

(4) the service area covered by each managed care organization;

(5) covered services, including services provided by the managed care organization and services provided by the commissioner;

(6) the provider directory and drug formulary for each managed care organization;

~~(7) cost-sharing requirements;~~

~~(8)~~ (7) requirements for adequate access to services, including provider network adequacy standards;

~~(9)~~ (8) a managed care organization's responsibility for coordination of enrollee care; and

~~(10)~~ (9) quality and performance indicators, including enrollee satisfaction for each managed care organization, if available.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 35. Minnesota Statutes 2020, section 256B.6925, subdivision 2, is amended to read:

Subd. 2. **Information provided by managed care organization.** The commissioner shall ensure that managed care organizations provide to each enrollee the following information:

(1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's enrollment. The handbook must, at a minimum, include information on benefits provided, how and where to access benefits, ~~cost-sharing requirements,~~ how transportation is provided, and other information as required by Code of Federal Regulations, part 42, section 438.10, paragraph (g);

(2) a provider directory for the following provider types: physicians, specialists, hospitals, pharmacies, behavioral health providers, and long-term supports and services providers, as appropriate. The directory must include the provider's name, group affiliation, street address, telephone number, website, specialty if applicable, whether the provider accepts new enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office accommodates people with disabilities;

(3) a drug formulary that includes both generic and name brand medications that are covered and each medication tier, if applicable;

(4) written notice of termination of a contracted provider. Within 15 calendar days after receipt or issuance of the termination notice, the managed care organization must make a

good faith effort to provide notice to each enrollee who received primary care from, or was seen on a regular basis by, the terminated provider; and

(5) upon enrollee request, the managed care organization's physician incentive plan.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 36. Minnesota Statutes 2020, section 256B.6928, subdivision 3, is amended to read:

Subd. 3. **Rate development standards.** (a) In developing capitation rates, the commissioner shall:

(1) identify and develop base utilization and price data, including validated encounter data and audited financial reports received from the managed care organizations that demonstrate experience for the populations served by the managed care organizations, for the three most recent and complete years before the rating period;

(2) develop and apply reasonable trend factors, including cost and utilization, to base data that are developed from actual experience of the medical assistance population or a similar population according to generally accepted actuarial practices and principles;

(3) develop the nonbenefit component of the rate to account for reasonable expenses related to the managed care organization's administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital and other operational costs associated with the managed care organization's provision of covered services to enrollees;

~~(4) consider the value of cost-sharing for rate development purposes, regardless of whether the managed care organization imposes the cost-sharing on the enrollee or the cost-sharing is collected by the provider;~~

~~(5)~~ (4) make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, changes to nonbenefit components, and any other adjustment necessary to establish actuarially sound rates. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, reflect the health status of the enrolled population, and be developed in accordance with generally accepted actuarial principles and practices;

~~(6)~~ (5) consider the managed care organization's past medical loss ratio in the development of the capitation rates and consider the projected medical loss ratio; and

~~(7)~~ (6) select a prospective or retrospective risk adjustment methodology that must be developed in a budget-neutral manner consistent with generally accepted actuarial principles and practices.

(b) The base data must be derived from the medical assistance population or, if data on the medical assistance population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to the medical assistance population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification. If the commissioner is unable to base the rates on data that are within the three most recent and complete years before the rating period, the commissioner may request an approval from the Centers for Medicare and Medicaid Services for an exception. The request must describe why an exception is necessary and describe the actions that the commissioner intends to take to comply with the request.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 37. Minnesota Statutes 2020, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical

assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments

made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(i) Medical assistance may reimburse for the cost incurred to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients when the sample is collected outside of an inpatient hospital setting or freestanding birth center setting because the newborn was born outside of a hospital or freestanding birth center or because it is not medically appropriate to collect the sample during the inpatient stay for the birth.

Sec. 38. Minnesota Statutes 2020, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except special education services and that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. ~~Children are exempt from the provisions of subdivision 5, regarding co-payments.~~ Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 39. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016, or after December 31, 2022.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Paragraphs (a) to (c) apply only to services provided through December 31, 2022. Effective for services provided on or after January 1, 2023, the MinnesotaCare program shall not require deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing.

Sec. 40. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner ~~shall~~ must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

Sec. 41. Minnesota Statutes 2020, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with an income less than or equal to 200 percent of the federal poverty guidelines must not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature that implementation of this section will not result in federal penalties to federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of

the federal poverty guidelines. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2020, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature that implementation of this section will not result in federal penalties to federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2020, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under age 19, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 44. Minnesota Statutes 2020, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7, who meet all

other MinnesotaCare eligibility requirements, are eligible for MinnesotaCare. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature that implementation of this section will not result in federal penalties to federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 45. Minnesota Statutes 2020, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines~~,~~ are no longer eligible for the program and ~~shall~~ must be disenrolled by the commissioner, unless the individuals continue MinnesotaCare enrollment through the public option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature that implementation of this section will not result in federal penalties to federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2021 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the

MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).~~

~~(c)~~ (b) Paragraph ~~(b)~~ (a) does not apply to~~:~~

~~(1)~~ children 20 years of age or younger~~; and~~.

~~(2) individuals with household incomes below 35 percent of the federal poverty guidelines.~~

~~(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:~~

~~**Federal Poverty Guideline Greater than or Equal to**~~	~~**Less than**~~	~~**Individual Premium Amount**~~
~~35%~~	~~55%~~	~~$4~~
~~55%~~	~~80%~~	~~$6~~
~~80%~~	~~90%~~	~~$8~~
~~90%~~	~~100%~~	~~$10~~
~~100%~~	~~110%~~	~~$12~~
~~110%~~	~~120%~~	~~$14~~
~~120%~~	~~130%~~	~~$15~~
~~130%~~	~~140%~~	~~$16~~
~~140%~~	~~150%~~	~~$25~~
~~150%~~	~~160%~~	~~$37~~
~~160%~~	~~170%~~	~~$44~~
~~170%~~	~~180%~~	~~$52~~
~~180%~~	~~190%~~	~~$61~~
~~190%~~	~~200%~~	~~$71~~
~~200%~~		~~$80~~

~~(e)~~ (c) Beginning January 1, ~~2021~~ 2023, the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31, 2022, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall adjust the premium scale ~~established under paragraph (d)~~ as needed to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(d) The commissioner shall establish a sliding premium scale for persons eligible through the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2025, persons eligible through the buy-in option shall pay premiums according to the premium scale established by the commissioner. Persons 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective January 1, 2023, except that the sliding premium scale established under paragraph (d) is effective January 1, 2025, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature that implementation of paragraph (d) will not result in federal penalties to federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by Laws 2015, First Special Session chapter 6, section 1, is amended to read:

Subd. 5. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	13,133,000	8,715,000
Federal TANF	96,311,000	96,311,000

(b) **Basic Sliding Fee Child Care Assistance Grants** 48,439,000 51,559,000

Basic Sliding Fee Waiting List Allocation. Notwithstanding Minnesota Statutes, section 119B.03, $5,413,000 in fiscal year 2016 is to reduce the basic sliding fee program waiting list as follows:

(1) The calendar year 2016 allocation shall be increased to serve families on the waiting list. To receive funds appropriated for this purpose, a county must have:

(i) a waiting list in the most recent published waiting list month;

(ii) an average of at least ten families on the most recent six months of published waiting list; and

(iii) total expenditures in calendar year 2014 that met or exceeded 80 percent of the county's available final allocation.

(2) Funds shall be distributed proportionately based on the average of the most recent six months of published waiting lists to counties that meet the criteria in clause (1).

(3) Allocations in calendar years 2017 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03.

(4) The guaranteed floor for calendar year 2017 shall be based on the revised calendar year 2016 allocation.

Base Level Adjustment. The general fund base is increased by $810,000 in fiscal year 2018 and increased by $821,000 in fiscal year 2019.

(c) **Child Care Development Grants**	1,737,000	1,737,000
(d) **Child Support Enforcement Grants**	50,000	50,000
(e) **Children's Services Grants**		
Appropriations by Fund		
General	39,015,000	38,665,000
Federal TANF	140,000	140,000

Safe Place for Newborns. $350,000 from the general fund in fiscal year 2016 is to distribute information on the Safe Place for Newborns

law in Minnesota to increase public awareness of the law. This is a onetime appropriation.

Child Protection. $23,350,000 in fiscal year 2016 and $23,350,000 in fiscal year 2017 are to address child protection staffing and services under Minnesota Statutes, section 256M.41. $1,650,000 in fiscal year 2016 and $1,650,000 in fiscal year 2017 are for child protection grants to address child welfare disparities under Minnesota Statutes, section 256E.28.

Title IV-E Adoption Assistance. Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2016 and 2017 for adoption incentive grants are appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

(f) **Children and Community Service Grants**	56,301,000	56,301,000
(g) **Children and Economic Support Grants**	26,778,000	26,966,000

Mobile Food Shelf Grants. (a) $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are for a grant to Hunger Solutions. This is a onetime appropriation and is available until June 30, 2017.

(b) Hunger Solutions shall award grants of up to $75,000 on a competitive basis. Grant applications must include:

(1) the location of the project;

(2) a description of the mobile program, including size and scope;

(3) evidence regarding the unserved or underserved nature of the community in which the project is to be located;

(4) evidence of community support for the project;

(5) the total cost of the project;

(6) the amount of the grant request and how funds will be used;

(7) sources of funding or in-kind contributions for the project that will supplement any grant award;

(8) a commitment to mobile programs by the applicant and an ongoing commitment to maintain the mobile program; and

(9) any additional information requested by Hunger Solutions.

(c) Priority may be given to applicants who:

(1) serve underserved areas;

(2) create a new or expand an existing mobile program;

(3) serve areas where a high amount of need is identified;

(4) provide evidence of strong support for the project from citizens and other institutions in the community;

(5) leverage funding for the project from other private and public sources; and

(6) commit to maintaining the program on a multilayer basis.

Homeless Youth Act. At least $500,000 of the appropriation for the Homeless Youth Act must be awarded to providers in greater Minnesota, with at least 25 percent of this amount for new applicant providers. The commissioner shall provide outreach and technical assistance to greater Minnesota providers and new providers to encourage responding to the request for proposals.

Stearns County Veterans Housing. $85,000 in fiscal year 2016 and $85,000 in fiscal year 2017 are for a grant to Stearns County to provide administrative funding in support of a service provider serving veterans in Stearns County. The administrative funding grant may be used to support group residential housing services, corrections-related services, veteran services, and other social services related to the service provider serving veterans in Stearns County.

Safe Harbor. $800,000 in fiscal year 2016 and $800,000 in fiscal year 2017 are from the general fund for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of sexual exploitation. Of this appropriation, $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are from the general fund for statewide youth outreach workers connecting sexually exploited youth and youth at risk of sexual exploitation with shelter and services.

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2016 do not cancel but are available for this purpose in fiscal year 2017.

Base Level Adjustment. The general fund base is decreased by $816,000 in fiscal year 2018 and is decreased by $606,000 in fiscal year 2019.

(h) **Health Care Grants**

	Appropriations by Fund	
General	536,000	2,482,000
Health Care Access	3,341,000	3,465,000

Grants for Periodic Data Matching for Medical Assistance and MinnesotaCare. Of the general fund appropriation, $26,000 in fiscal year 2016 and $1,276,000 in fiscal year 2017 are for grants to counties for costs related to periodic data matching for medical assistance and MinnesotaCare recipients under Minnesota Statutes, section 256B.0561. The commissioner must distribute these grants to counties in proportion to each county's number of cases in the prior year in the affected programs.

Base Level Adjustment. The general fund base is ~~increased by $1,637,000 in fiscal year 2018 and increased by $1,229,000 in fiscal year 2019~~ maintained in fiscal years 2020 and 2021.

(i) **Other Long-Term Care Grants** 1,551,000 3,069,000

Transition Populations. $1,551,000 in fiscal year 2016 and $1,725,000 in fiscal year 2017 are for home and community-based services

transition grants to assist in providing home and community-based services and treatment for transition populations under Minnesota Statutes, section 256.478.

Base Level Adjustment. The general fund base is increased by $156,000 in fiscal year 2018 and by $581,000 in fiscal year 2019.

(j) **Aging and Adult Services Grants** 28,463,000 28,162,000

Dementia Grants. $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are for the Minnesota Board on Aging for regional and local dementia grants authorized in Minnesota Statutes, section 256.975, subdivision 11.

(k) **Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

Deaf, Deafblind, and Hard-of-Hearing Grants. $350,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are for deaf and hard-of-hearing grants. The funds must be used to increase the number of deafblind Minnesotans receiving services under Minnesota Statutes, section 256C.261, and to provide linguistically and culturally appropriate mental health services to children who are deaf, deafblind, and hard-of-hearing. This is a onetime appropriation.

Base Level Adjustment. The general fund base is decreased by $500,000 in fiscal year 2018 and by $500,000 in fiscal year 2019.

(l) **Disabilities Grants** 20,820,000 20,858,000

State Quality Council. $573,000 in fiscal year 2016 and $600,000 in fiscal year 2017 are for the State Quality Council to provide technical assistance and monitoring of

person-centered outcomes related to inclusive community living and employment. The funding must be used by the State Quality Council to assure a statewide plan for systems change in person-centered planning that will achieve desired outcomes including increased integrated employment and community living.

(m) **Adult Mental Health Grants**

	Appropriations by Fund	
General	69,992,000	71,244,000
Health Care Access	1,575,000	2,473,000
Lottery Prize	1,733,000	1,733,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Culturally Specific Mental Health Services. $100,000 in fiscal year 2016 is for grants to nonprofit organizations to provide resources and referrals for culturally specific mental health services to Southeast Asian veterans born before 1965 who do not qualify for services available to veterans formally discharged from the United States armed forces.

Problem Gambling. $225,000 in fiscal year 2016 and $225,000 in fiscal year 2017 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to

problem gamblers and their families, and research related to problem gambling.

Sustainability Grants. $2,125,000 in fiscal year 2016 and $2,125,000 in fiscal year 2017 are for sustainability grants under Minnesota Statutes, section 256B.0622, subdivision 11.

Beltrami County Mental Health Services Grant. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for a grant to Beltrami County to fund the planning and development of a comprehensive mental health services program under article 2, section 41, Comprehensive Mental Health Program in Beltrami County. This is a onetime appropriation.

Base Level Adjustment. The general fund base is increased by $723,000 in fiscal year 2018 and by $723,000 in fiscal year 2019. The health care access fund base is decreased by $1,723,000 in fiscal year 2018 and by $1,723,000 in fiscal year 2019.

(n) **Child Mental Health Grants**	23,386,000	24,313,000

Services and Supports for First Episode Psychosis. $177,000 in fiscal year 2017 is for grants under Minnesota Statutes, section 245.4889, to mental health providers to pilot evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and for a public awareness campaign on the signs and symptoms of psychosis. The base for these grants is $236,000 in fiscal year 2018 and $301,000 in fiscal year 2019.

Adverse Childhood Experiences. The base for grants under Minnesota Statutes, section 245.4889, to children's mental health and family services collaboratives for adverse childhood experiences (ACEs) training grants and for an interactive Web site connection to support ACEs in Minnesota is $363,000 in fiscal year 2018 and $363,000 in fiscal year 2019.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Level Adjustment. The general fund base is increased by $422,000 in fiscal year 2018 and is increased by $487,000 in fiscal year 2019.

(o) **Chemical Dependency Treatment Support Grants**	1,561,000	1,561,000

Chemical Dependency Prevention. $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are for grants to nonprofit organizations to provide chemical dependency prevention programs in secondary schools. When making grants, the commissioner must consider the expertise, prior experience, and outcomes achieved by applicants that have provided prevention programming in secondary education environments. An applicant for the grant funds must provide verification to the commissioner that the applicant has available and will contribute sufficient funds to match the grant given by the commissioner. This is a onetime appropriation.

Fetal Alcohol Syndrome Grants. $250,000 in fiscal year 2016 and $250,000 in fiscal year 2017 are for grants to be administered by the Minnesota Organization on Fetal Alcohol Syndrome to provide comprehensive, gender-specific services to pregnant and parenting women suspected of or known to use or abuse alcohol or other drugs. This appropriation is for grants to no fewer than three eligible recipients. Minnesota Organization on Fetal Alcohol Syndrome must report to the commissioner of human services annually by January 15 on the grants funded by this appropriation. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born.

Base Level Adjustment. The general fund base is decreased by $150,000 in fiscal year 2018 and by $150,000 in fiscal year 2019.

Sec. 48. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

Subdivision 1. **Waivers and modifications; federal funding extension.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following waivers and modifications to human services programs issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12 that are required to comply with federal law may remain in effect for the time period set out in applicable federal law or for the time period set out in any applicable federally approved waiver or state plan amendment, whichever is later:

(1) CV15: allowing telephone or video visits for waiver programs;

(2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare as needed to comply with federal guidance from the Centers for Medicare and Medicaid

Services, and until the enrollee's first renewal following the resumption of medical assistance and MinnesotaCare renewals after the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services;

(3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

(5) CV24: allowing telephone or video use for targeted case management visits;

(6) CV30: expanding telemedicine in health care, mental health, and substance use disorder settings;

(7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(10) CV43: expanding remote home and community-based waiver services;

(11) CV44: allowing remote delivery of adult day services;

(12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance Program;

(13) CV60: modifying eligibility period for the federally funded Refugee Social Services Program; and

(14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and Minnesota Family Investment Program maximum food benefits.

Sec. 49. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to read:

Sec. 36. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

(a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06, subdivision 3, or any other provision to the contrary, the commissioner shall not collect any unpaid premium for a coverage month ~~that occurred during~~ until the enrollee's first renewal after the resumption of medical assistance renewals following the end of the COVID-19

public health emergency declared by the United States Secretary of Health and Human Services.

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12 months following the ~~last day of~~ resumption of medical assistance and MinnesotaCare renewals after the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(c) Notwithstanding any provision to the contrary, the requirement for the commissioner of human services to issue an annual report on periodic data matching under Minnesota Statutes, section 256B.0561, is suspended for one year following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(d) The commissioner of human services shall take necessary actions to comply with federal guidance pertaining to the appropriate redetermination of medical assistance enrollee eligibility following the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services and may waive currently existing Minnesota statutes to the minimum level necessary to achieve federal compliance. All changes implemented must be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over human services within 90 days.

Sec. 50. **DENTAL HOME PILOT PROJECT.**

Subdivision 1. **Establishment; requirements.** (a) The commissioner of human services shall establish a dental home pilot project to increase access of medical assistance and MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health clinical outcomes, in a manner that sustains the financial viability of the dental workforce and broader dental care delivery and financing system. Dental homes must provide high-quality, patient-centered, comprehensive, and coordinated oral health services across clinical and community-based settings, including virtual oral health care.

(b) The design and operation of the dental home pilot project must be consistent with the recommendations made by the Dental Services Advisory Committee to the legislature under Laws 2021, First Special Session chapter 7, article 1, section 33.

(c) The commissioner shall establish baseline requirements and performance measures for dental homes participating in the pilot project. These baseline requirements and

performance measures must address access and patient experience and oral health clinical outcomes.

Subd. 2. **Project design and timeline.** (a) The commissioner shall issue a preliminary project description and a request for information to obtain stakeholder feedback and input on project design issues, including but not limited to:

(1) the timeline for project implementation;

(2) the length of each project phase and the date for full project implementation;

(3) the number of providers to be selected for participation;

(4) grant amounts;

(5) criteria and procedures for any value-based payments;

(6) the extent to which pilot project requirements may vary with provider characteristics;

(7) procedures for data collection;

(8) the role of dental partners, such as dental professional organizations and educational institutions;

(9) provider support and education; and

(10) other topics identified by the commissioner.

(b) The commissioner shall consider the feedback and input obtained in paragraph (a) and shall develop and issue a request for proposals for participation in the pilot project.

(c) The pilot project must be implemented by July 1, 2023, and must include initial pilot testing and the collection and analysis of data on baseline requirements and performance measures to evaluate whether these requirements and measures are appropriate. Under this phase, the commissioner shall provide grants to individual providers and provider networks in addition to medical assistance and MinnesotaCare payments received for services provided.

(d) The pilot project may test and analyze value-based payments to providers to determine whether varying payments based on dental home performance measures is appropriate and effective.

(e) The commissioner shall ensure provider diversity in selecting project participants. In selecting providers, the commissioner shall consider: geographic distribution; provider size, type, and location; providers serving different priority populations; health equity issues; and provider accessibility for patients with varying levels and types of disability.

(f) In designing and implementing the pilot project, the commissioner shall regularly consult with project participants and other stakeholders, and as relevant shall continue to seek the input of participants and other stakeholders on the topics listed in paragraph (a).

Subd. 3. **Reporting.** (a) The commissioner, beginning February 15, 2023, and each February 15 thereafter for the duration of the demonstration project, shall report on the design, implementation, operation, and results of the demonstration project to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

(b) The commissioner, within six months from the date the pilot project ceases operation, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy on the results of the demonstration project, and shall include in the report recommendations on whether the demonstration project, or specific features of the demonstration project, should be extended to all dental providers serving medical assistance and MinnesotaCare enrollees.

Sec. 51. **SMALL EMPLOYER PUBLIC OPTION.**

The commissioner of human services, in consultation with representatives of small employers, shall develop a small employer public option that allows employees of businesses with fewer than 50 employees to receive employer contributions toward MinnesotaCare. The commissioner shall determine whether the employer makes contributions to the commissioner directly or the employee makes contributions through a qualified small employer health reimbursement arrangement account or other arrangement. In determining the structure of the small employer public option, the commissioner shall consult with federal officials to determine which arrangement will result in the employer contributions being tax deductible to the employer and not being considered taxable income to the employee. The commissioner shall present recommendations for a small employer public option to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 15, 2023.

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

Sec. 52. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

(a) The commissioner of human services shall continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5, and shall seek federal waivers, approvals, and law changes necessary to implement this act.

(b) The commissioner shall present an implementation plan for the MinnesotaCare public option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2023. The plan must include:

(1) recommendations for any changes to the MinnesotaCare public option necessary to continue federal basic health program funding or to receive other federal funding;

(2) recommendations for implementing any small employer option in a manner that would allow any employee payments toward premiums to be pretax;

(3) recommendations for ensuring sufficient provider participation in MinnesotaCare;

(4) estimates of state costs related to the MinnesotaCare public option;

(5) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the proposed premium scale:

(i) ensures affordable premiums for persons across the income spectrum enrolled under the public option; and

(ii) avoids premium cliffs for persons transitioning to and enrolled under the public option; and

(6) draft legislation that includes any additional policy and conforming changes necessary to implement the MinnesotaCare public option and the implementation plan recommendations.

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

Sec. 53. **REQUEST FOR FEDERAL APPROVAL.**

(a) The commissioner of human services shall seek any federal waivers, approvals, and law changes necessary to implement this act, including but not limited to those waivers, approvals, and law changes necessary to allow the state to:

(1) continue receiving federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option;

(2) receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would otherwise have received; and

(3) receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for covered services provided to eligible enrollees.

(b) In implementing this section, the commissioner of human services shall consult with the commissioner of commerce and the Board of Directors of MNsure and may contract for technical and actuarial assistance.

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

Sec. 54. **DELIVERY REFORM ANALYSIS REPORT.**

(a) The commissioner of human services shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2024, a report comparing service delivery and payment system models for delivering services to medical assistance enrollees for whom income eligibility is determined using the modified adjusted gross income methodology under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible under Minnesota Statutes, chapter 256L. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(b) The report must include:

(1) a description of how each model would address:

(i) racial and other inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) the provision of incentives for preventive care and other best practices;

(iv) reimbursement of providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care; and

(v) transparency and simplicity for enrollees, health care providers, and policymakers;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model that includes the earliest date by which each model could be implemented if authorized during the 2024 legislative session and a discussion of barriers to implementation.

Sec. 55. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

(a) The commissioners of human services, health, and commerce and the MNsure board shall submit to the health care affordability board and the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services finance and policy and commerce by January 15, 2023, a report on the organization and duties of the Office of Patient Protection, to be established under Minnesota Statutes, section 62J.89, subdivision 4. The report must include recommendations on how the office shall:

(1) coordinate or consolidate within the office existing state agency patient protection activities, including but not limited to the activities of ombudsman offices and the MNsure board;

(2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for utilization review organizations;

(3) work with private sector and state agency consumer assistance programs to assist consumers with questions or concerns relating to public programs and private insurance coverage;

(4) establish and implement procedures to assist consumers aggrieved by restrictions on patient choice, denials of services, and reductions in quality of care resulting from any final action by a payer or provider; and

(5) make health plan company quality of care and patient satisfaction information and other information collected by the office readily accessible to consumers on the board's website.

(b) The commissioners and the MNsure board shall consult with stakeholders as they develop the recommendations. The stakeholders consulted must include but are not limited to organizations and individuals representing: underserved communities; persons with

disabilities; low-income Minnesotans; senior citizens; and public and private sector health plan enrollees, including persons who purchase coverage through MNsure, health plan companies, and public and private sector purchasers of health coverage.

(c) The commissioners and the MNsure board may contract with a third party to develop the report and recommendations.

Sec. 56. **REPEALER.**

Minnesota Statutes 2020, section 256B.063, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2023.

ARTICLE 4
HEALTH CARE POLICY

Section 1. Minnesota Statutes 2020, section 62J.2930, subdivision 3, is amended to read:

Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;

(3) provide information on coverage options in each region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section ~~256B.69, subdivision 20~~ 256B.6903, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 2020, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for Title IV-E of the Social Security Act but who is ~~determined eligible for~~ placed in foster care as determined by Minnesota Statutes or kinship assistance under chapter 256N.

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

Sec. 3. Minnesota Statutes 2020, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning to Minnesota health care program funds, and that trust instruments should not be permitted to shield available resources of an individual or an individual's spouse from such use.

~~(a)~~ (b) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

~~(b)~~ (c) Trusts established after August 10, 1993, are treated according to United States Code, title 42, section 1396p(d).

~~(c)~~ (d) For purposes of paragraph ~~(d)~~ (e), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

~~(d)~~ (e) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during

the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

~~(e)~~ (f) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

Sec. 4. Minnesota Statutes 2020, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered;

(7) assets owned by children are not considered; and

(8) ~~effective July 1, 2009,~~ certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) ~~Beginning January 1, 2014, this subdivision~~ Paragraph (a) applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.

(c) Eligibility for children under age 21 must be determined without regard to the asset limitations described in paragraphs (a) and (b) and subdivision 3.

Sec. 5. Minnesota Statutes 2020, section 256B.056, subdivision 11, is amended to read:

Subd. 11. **Treatment of annuities.** (a) Any person requesting medical assistance payment of long-term care services shall provide a complete description of any interest either the person or the person's spouse has in annuities on a form designated by the department. The form shall include a statement that the state becomes a preferred remainder beneficiary of annuities or similar financial instruments by virtue of the receipt of medical assistance payment of long-term care services. The person and the person's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents and complete the form designating the state as the preferred remainder beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) The department shall provide notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the person or the person's spouse, and provide notice of the issuer's responsibilities as provided in paragraph (c).

(c) An issuer of an annuity or similar financial instrument who receives notice of the state's right to be named a preferred remainder beneficiary as described in paragraph (b) shall provide confirmation to the requesting agency that the state has been made a preferred remainder beneficiary. The issuer shall also notify the county agency when a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument or a change in the state's preferred remainder beneficiary designation under the annuity or other similar financial instrument occurs. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position

in an amount equal to the amount of medical assistance paid on behalf of the institutionalized person, or is a remainder beneficiary in the second position if the institutionalized person designates and is survived by a remainder beneficiary who is (1) a spouse who does not reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. Notwithstanding this paragraph, the state is the remainder beneficiary in the first position if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care services" have the meanings given in section 256B.0595, subdivision 1, paragraph ~~(g)~~ (f).

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital.

Sec. 6. Minnesota Statutes 2020, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10, 1993, an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the Supplemental Security Income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time

after an institutionalized person requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

(b) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the institutionalized person or the institutionalized person's spouse is entitled but does not receive due to action by the institutionalized person, the institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse.

(c) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement ~~which~~ that was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

~~(d) This section applies to the portion of any asset or interest that an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy as determined according to the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity purchased on or after March 1, 2002, that:~~

~~(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;~~

~~(2) does not pay out principal and interest in equal monthly installments; or~~

~~(3) does not begin payment at the earliest possible date after annuitization.~~

~~(e)~~ (d) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person who has applied for or is receiving long-term care services or the institutionalized person's spouse shall be treated

as the disposal of an asset for less than fair market value unless the department is named a preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any subsequent change to the designation of the department as a preferred remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the institutionalized person or the institutionalized person's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the institutionalized person or the institutionalized person's spouse demonstrates that the transaction was for fair market value. In the event a distribution of income or principal has been improperly distributed or disbursed from an annuity or other retirement planning instrument of an institutionalized person or the institutionalized person's spouse, a cause of action exists against the individual receiving the improper distribution for the cost of medical assistance services provided or the amount of the improper distribution, whichever is less.

~~(f)~~ (e) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is:

(1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(2) purchased with proceeds from:

(i) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(ii) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(iii) a Roth IRA described in section 408A of the Internal Revenue Code; or

(3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

~~(g)~~ (f) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision

2, because they are provided in a swing bed, intermediate care facility for persons with developmental disabilities, and home and community-based services provided pursuant to chapter 256S and sections 256B.092 and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with developmental disabilities or who is receiving home and community-based services under chapter 256S and sections 256B.092 and 256B.49.

~~(h)~~ (g) This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

(h) In the case of a promissory note, loan, or mortgage that does not meet an exception in paragraph (g), clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the institutionalized person's request for medical assistance payment of long-term care services.

(i) This section applies to the purchase of a life estate interest in another person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

(j) This section applies to transfers into a pooled trust that qualifies under United States Code, title 42, section 1396p(d)(4)(C), by:

(1) a person age 65 or older or the person's spouse; or

(2) any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of a person age 65 or older or the person's spouse.

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

Sec. 7. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner

as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits~~, as described in this subdivision provided through audio and visual communication,~~ may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For mental health services or assessments delivered through telehealth that are based on an individual treatment plan, the provider may document the client's verbal approval or electronic written approval of the treatment plan or change in the treatment plan in lieu of the client's signature in accordance with Minnesota Rules, part 9505.0371.

(f) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations ~~through the use of~~ using real-time two-way interactive audio and visual communication or accessible telemedicine video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing~~,~~ consisting of a real-time, full-motion synchronized video; store-and-forward technology~~,~~; and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, e-mail, or facsimile transmission or as specified by law;

(2) "health care provider" means:

(i) a health care provider as defined under section 62A.673~~,~~;

(ii) a community paramedic as defined under section 144E.001, subdivision 5f~~,~~;

(iii) a community health worker who meets the criteria under subdivision 49, paragraph (a)~~,~~;

(iv) a mental health certified peer specialist under section 256B.0615, subdivision 5~~,~~;

(v) a mental health certified family peer specialist under section 256B.0616, subdivision 5~~,~~;

(vi) a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b)~~,~~;

(vii) a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3)~~,~~;

(viii) a treatment coordinator under section 245G.11, subdivision 7~~,~~;

(ix) an alcohol and drug counselor under section 245G.11, subdivision 5~~,~~; or

(x) a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, devices, and clinical trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover the costs of any services that are incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in section 151.375 or any other treatment that is part of an approved clinical trial as defined in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude coverage of medically necessary services covered under this chapter that are not related to the approved clinical trial. Any items or services that are provided solely to satisfy data collection and analysis for a clinical trial, and not for direct clinical management of the enrollee, are not covered.

Sec. 9. **[256B.6903] OMBUDSPERSON FOR MANAGED CARE.**

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

(b) "Adverse benefit determination" has the meaning provided in Code of Federal Regulations, title 42, section 438.400, subpart (b).

(c) "Appeal" means an oral or written request from an enrollee to the managed care organization for review of an adverse benefit determination.

(d) "Commissioner" means the commissioner of human services.

(e) "Complaint" means an enrollee's informal expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination.

(f) "Data analyst" means the person employed by the ombudsperson that uses research methodologies to conduct research on data collected from prepaid health plans, including

but not limited to scientific theory; hypothesis testing; survey research techniques; data collection; data manipulation; and statistical analysis interpretation, including multiple regression techniques.

(g) "Enrollee" means a person enrolled in a prepaid health plan under section 256B.69. When applicable, an enrollee includes an enrollee's authorized representative.

(h) "External review" means the process described under Code of Federal Regulations, title 42, section 438.408, subpart (f); and section 62Q.73, subdivision 2.

(i) "Grievance" means an enrollee's expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination that follows the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A grievance may include but is not limited to concerns relating to quality of care, services provided, or failure to respect an enrollee's rights under a prepaid health plan.

(j) "Managed care advocate" means a county or Tribal employee who works with managed care enrollees when the enrollee has service, billing, or access problems with the enrollee's prepaid health plan.

(k) "Prepaid health plan" means a plan under contract with the commissioner according to section 256B.69.

(l) "State fair hearing" means the appeals process mandated under section 256.045, subdivision 3a.

Subd. 2. **Ombudsperson.** The commissioner must designate an ombudsperson to advocate for enrollees. At the time of enrollment in a prepaid health plan, the local agency must inform enrollees about the ombudsperson.

Subd. 3. **Duties and cost.** (a) The ombudsperson must work to ensure enrollees receive covered services as described in the enrollee's prepaid health plan by:

(1) providing assistance and education to enrollees, when requested, regarding covered health care benefits or services; billing and access; or the grievance, appeal, or state fair hearing processes;

(2) with the enrollee's permission and within the ombudsperson's discretion, using an informal review process to assist an enrollee with a resolution involving the enrollee's prepaid health plan's benefits;

(3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or the state fair hearing process;

(4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid health plans' grievances, appeals, and state fair hearings;

(5) reviewing all state fair hearings and requests by enrollees for external review; overseeing entities under contract to provide external reviews, processes, and payments for services; and utilizing aggregated results of external reviews to recommend health care benefits policy changes; and

(6) providing trainings to managed care advocates.

(b) The ombudsperson must not charge an enrollee for the ombudsperson's services.

Subd. 4. **Powers.** In exercising the ombudsperson's authority under this section, the ombudsperson may:

(1) gather information and evaluate any practice, policy, procedure, or action by a prepaid health plan, state human services agency, county, or Tribe; and

(2) prescribe the methods by which complaints are to be made, received, and acted upon. The ombudsperson's authority under this clause includes but is not limited to:

(i) determining the scope and manner of a complaint;

(ii) holding a prepaid health plan accountable to address a complaint in a timely manner as outlined in state and federal laws;

(iii) requiring a prepaid health plan to respond in a timely manner to a request for data, case details, and other information as needed to help resolve a complaint or to improve a prepaid health plan's policy; and

(iv) making recommendations for policy, administrative, or legislative changes regarding prepaid health plans to the proper partners.

Subd. 5. **Data.** (a) The data analyst must review and analyze prepaid health plan data on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair hearings by:

(1) analyzing, reviewing, and reporting on DTRs, grievances, appeals, and state fair hearings data collected from each prepaid health plan;

(2) collaborating with the commissioner's partners and the Department of Health for the Triennial Compliance Assessment under Code of Federal Regulations, title 42, section 438.358, subpart (b);

(3) reviewing state fair hearing decisions for policy or coverage issues that may affect enrollees; and

(4) providing data required under Code of Federal Regulations, title 42, section 438.66 (2016), to the Centers for Medicare and Medicaid Services.

(b) The data analyst must share the data analyst's data observations and trends under this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.

Subd. 6. **Collaboration and independence.** (a) The ombudsperson must work in collaboration with the commissioner and the commissioner's partners when the ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties under this section.

(b) The ombudsperson may act independently of the commissioner when:

(1) providing information or testimony to the legislature; and

(2) contacting and making reports to federal and state officials.

Subd. 7. **Civil actions.** The ombudsperson is not civilly liable for actions taken under this section if the action was taken in good faith, was within the scope of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

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

Sec. 10. Minnesota Statutes 2020, section 256B.77, subdivision 13, is amended to read:

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section ~~256B.69, subdivision 20~~ 256B.6903, and advocacy services provided by the ombudsman for mental health and developmental disabilities established in sections 245.91 to 245.97. The managed care ombudsman and the ombudsman for mental health and developmental disabilities shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the Office of Ombudsman for Mental Health and Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

Sec. 11. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.057, subdivision 7, is repealed on July 1, 2022.

(b) Minnesota Statutes 2020, sections 256B.69, subdivision 20; 501C.0408, subdivision 4; and 501C.1206, are repealed the day following final enactment.

ARTICLE 5
HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2020, section 148B.33, is amended by adding a subdivision to read:

Subd. 1a. **Supervision requirement; postgraduate experience.** The board must allow an applicant to satisfy the requirement for supervised postgraduate experience in marriage and family therapy with all required hours of supervision provided through real-time, two-way interactive audio and visual communication.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 2. Minnesota Statutes 2021 Supplement, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional who is qualified according to section 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person or through real-time, two-way interactive audio and visual communication, and the board must allow an applicant to satisfy this supervision requirement with all required hours of supervision received through real-time, two-way interactive audio and visual communication. The remaining 25 percent of the required hours may be received

by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 3. Minnesota Statutes 2020, section 148E.100, subdivision 3, is amended to read:

Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under subdivision 1:

(1) 50 hours must be provided through one-on-one supervision~~, including: (i) a minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 4. Minnesota Statutes 2020, section 148E.105, subdivision 3, is amended to read:

Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under subdivision 1:

(1) 50 hours must be provided ~~though~~ through one-on-one supervision~~, including: (i) a minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while

maintaining visual contact. The board must allow a licensed graduate social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 5. Minnesota Statutes 2020, section 148E.106, subdivision 3, is amended to read:

Subd. 3. **Types of supervision.** Of the 200 hours of supervision required under subdivision 1:

(1) 100 hours must be provided through one-on-one supervision~~, including: (i) a minimum of 50 hours of in-person supervision, and (ii) no more than 50 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed graduate social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 100 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 6. Minnesota Statutes 2020, section 148E.110, subdivision 7, is amended to read:

Subd. 7. **Supervision; clinical social work practice after licensure as licensed independent social worker.** Of the 200 hours of supervision required under subdivision 5:

(1) 100 hours must be provided through one-on-one supervision~~, including:~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed independent social worker to

satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

~~(i) a minimum of 50 hours of in-person supervision; and~~

~~(ii) no more than 50 hours of supervision via eye-to-eye electronic media, while maintaining visual contact; and~~

(2) 100 hours must be provided through:

(i) one-on-one supervision; or

(ii) group supervision.

The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 7. Minnesota Statutes 2020, section 150A.06, subdivision 1c, is amended to read:

Subd. 1c. **Specialty dentists.** (a) The board may grant one or more specialty licenses in the specialty areas of dentistry that are recognized by the Commission on Dental Accreditation.

(b) An applicant for a specialty license shall:

(1) have successfully completed a postdoctoral specialty program accredited by the Commission on Dental Accreditation, or have announced a limitation of practice before 1967;

(2) have been certified by a specialty board approved by the Minnesota Board of Dentistry, or provide evidence of having passed a clinical examination for licensure required for practice in any state or Canadian province, or in the case of oral and maxillofacial surgeons only, have a Minnesota medical license in good standing;

(3) have been in active practice or a postdoctoral specialty education program or United States government service at least 2,000 hours in the 36 months prior to applying for a specialty license;

(4) if requested by the board, be interviewed by a committee of the board, which may include the assistance of specialists in the evaluation process, and satisfactorily respond to

questions designed to determine the applicant's knowledge of dental subjects and ability to practice;

(5) if requested by the board, present complete records on a sample of patients treated by the applicant. The sample must be drawn from patients treated by the applicant during the 36 months preceding the date of application. The number of records shall be established by the board. The records shall be reasonably representative of the treatment typically provided by the applicant for each specialty area;

(6) at board discretion, pass a board-approved English proficiency test if English is not the applicant's primary language;

(7) pass all components of the National Board Dental Examinations;

(8) pass the Minnesota Board of Dentistry jurisprudence examination;

(9) abide by professional ethical conduct requirements; and

(10) meet all other requirements prescribed by the Board of Dentistry.

(c) The application must include:

(1) a completed application furnished by the board;

~~(2) at least two character references from two different dentists for each specialty area, one of whom must be a dentist practicing in the same specialty area, and the other from the director of each specialty program attended;~~

~~(3) a licensed physician's statement attesting to the applicant's physical and mental condition;~~

~~(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's visual acuity;~~

~~(5)~~ (2) a nonrefundable fee; and

~~(6)~~ (3) a ~~notarized, unmounted passport-type photograph, three inches by three inches, taken not more than six months before the date of application~~ copy of the applicant's government issued photo identification card.

(d) A specialty dentist holding one or more specialty licenses is limited to practicing in the dentist's designated specialty area or areas. The scope of practice must be defined by each national specialty board recognized by the Commission on Dental Accreditation.

(e) A specialty dentist holding a general dental license is limited to practicing in the dentist's designated specialty area or areas if the dentist has announced a limitation of

practice. The scope of practice must be defined by each national specialty board recognized by the Commission on Dental Accreditation.

(f) All specialty dentists who have fulfilled the specialty dentist requirements and who intend to limit their practice to a particular specialty area or areas may apply for one or more specialty licenses.

Sec. 8. Minnesota Statutes 2020, section 150A.06, subdivision 2c, is amended to read:

Subd. 2c. **Guest license.** (a) The board shall grant a guest license to practice as a dentist, dental hygienist, or licensed dental assistant if the following conditions are met:

(1) the dentist, dental hygienist, or dental assistant is currently licensed in good standing in another United States jurisdiction;

(2) the dentist, dental hygienist, or dental assistant is currently engaged in the practice of that person's respective profession in another United States jurisdiction;

(3) the dentist, dental hygienist, or dental assistant will limit that person's practice to a public health setting in Minnesota that (i) is approved by the board; (ii) was established by a nonprofit organization that is tax exempt under chapter 501(c)(3) of the Internal Revenue Code of 1986; and (iii) provides dental care to patients who have difficulty accessing dental care;

(4) the dentist, dental hygienist, or dental assistant agrees to treat indigent patients who meet the eligibility criteria established by the clinic; and

(5) the dentist, dental hygienist, or dental assistant has applied to the board for a guest license and has paid a nonrefundable license fee to the board ~~not to exceed $75~~.

(b) A guest license must be renewed annually with the board and an annual renewal fee ~~not to exceed $75~~ must be paid to the board. Guest licenses expire on December 31 of each year.

(c) A dentist, dental hygienist, or dental assistant practicing under a guest license under this subdivision shall have the same obligations as a dentist, dental hygienist, or dental assistant who is licensed in Minnesota and shall be subject to the laws and rules of Minnesota and the regulatory authority of the board. If the board suspends or revokes the guest license of, or otherwise disciplines, a dentist, dental hygienist, or dental assistant practicing under this subdivision, the board shall promptly report such disciplinary action to the dentist's, dental hygienist's, or dental assistant's regulatory board in the jurisdictions in which they are licensed.

(d) The board may grant a guest license to a dentist, dental hygienist, or dental assistant licensed in another United States jurisdiction to provide dental care to patients on a voluntary basis without compensation for a limited period of time. The board shall not assess a fee for the guest license for volunteer services issued under this paragraph.

(e) The board shall issue a guest license for volunteer services if:

(1) the board determines that the applicant's services will provide dental care to patients who have difficulty accessing dental care;

(2) the care will be provided without compensation; and

(3) the applicant provides adequate proof of the status of all licenses to practice in other jurisdictions. The board may require such proof on an application form developed by the board.

(f) The guest license for volunteer services shall limit the licensee to providing dental care services for a period of time not to exceed ten days in a calendar year. Guest licenses expire on December 31 of each year.

(g) The holder of a guest license for volunteer services shall be subject to state laws and rules regarding dentistry and the regulatory authority of the board. The board may revoke the license of a dentist, dental hygienist, or dental assistant practicing under this subdivision or take other regulatory action against the dentist, dental hygienist, or dental assistant. If an action is taken, the board shall report the action to the regulatory board of those jurisdictions where an active license is held by the dentist, dental hygienist, or dental assistant.

Sec. 9. Minnesota Statutes 2020, section 150A.06, subdivision 6, is amended to read:

Subd. 6. **Display of name and certificates.** (a) The renewal certificate of ~~every dentist, dental therapist, dental hygienist, or dental assistant~~ every licensee or registrant must be conspicuously displayed in plain sight of patients in every office in which that person practices. Duplicate renewal certificates may be obtained from the board.

(b) Near or on the entrance door to every office where dentistry is practiced, the name of each dentist practicing there, as inscribed on the current license certificate, must be displayed in plain sight.

(c) The board must allow the display of a mini-license for guest license holders performing volunteer dental services. There is no fee for the mini-license for guest volunteers.

Sec. 10. Minnesota Statutes 2020, section 150A.06, is amended by adding a subdivision to read:

Subd. 12. **Licensure by credentials for dental therapy.** (a) Any dental therapist may, upon application and payment of a fee established by the board, apply for licensure based on an evaluation of the applicant's education, experience, and performance record. The applicant may be interviewed by the board to determine if the applicant:

(1) graduated with a baccalaureate or master's degree from a dental therapy program accredited by the Commission on Dental Accreditation;

(2) provided evidence of successfully completing the board's jurisprudence examination;

(3) actively practiced at least 2,000 hours within 36 months of the application date or passed a board-approved reentry program within 36 months of the application date;

(4) either:

(i) is currently licensed in another state or Canadian province and not subject to any pending or final disciplinary action; or

(ii) was previously licensed in another state or Canadian province in good standing and not subject to any final or pending disciplinary action at the time of surrender;

(5) passed a board-approved English proficiency test if English is not the applicant's primary language required at the board's discretion; and

(6) met all curriculum equivalency requirements regarding dental therapy scope of practice in Minnesota.

(b) The 2,000 practice hours required by clause (3) may count toward the 2,000 practice hours required for consideration for advanced dental therapy certification, provided that all other requirements of section 150A.106, subdivision 1, are met.

(c) The board, at its discretion, may waive specific licensure requirements in paragraph (a).

(d) The board must license an applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 1d to practice the applicant's profession.

(e) The board must deny the application if the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 1d. If licensure is denied, the board may notify the applicant of any specific remedy the applicant

could take to qualify for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 1d.

(e) A candidate may appeal a denied application to the board according to subdivision 4a.

Sec. 11. Minnesota Statutes 2020, section 150A.09, is amended to read:

150A.09 ~~REGISTRATION OF~~ LICENSES ~~AND~~ OR REGISTRATION CERTIFICATES.

Subdivision 1. **Registration information and procedure.** On or before the license certificate expiration date every ~~licensed dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall ~~transmit to the executive secretary of the board, pertinent information~~ submit the renewal required by the board, together with the applicable fee ~~established by the board~~ under section 150A.091. At least 30 days before a license certificate expiration date, the board shall send a written notice stating the amount and due date of the fee ~~and the information to be provided to every licensed dentist, dental therapist, dental hygienist, and dental assistant~~.

Subd. 3. **Current address, change of address.** Every ~~dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall maintain with the board a correct and current mailing address and electronic mail address. For dentists engaged in the practice of dentistry, the postal address shall be that of the location of the primary dental practice. Within 30 days after changing postal or electronic mail addresses, every ~~dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall provide the board ~~written~~ notice ~~of the new address either personally or by first class mail~~.

Subd. 4. **Duplicate certificates.** Duplicate licenses or duplicate certificates of ~~license~~ renewal may be issued by the board upon satisfactory proof of the need for the duplicates and upon payment of the fee established by the board.

Subd. 5. **Late fee.** A late fee established by the board shall be paid if the ~~information and~~ fee required by subdivision 1 is not received by ~~the executive secretary of~~ the board on or before the registration or ~~license~~ renewal date.

Sec. 12. Minnesota Statutes 2020, section 150A.091, subdivision 2, is amended to read:

Subd. 2. **Application and initial license or registration fees.** Each applicant shall submit with a license, advanced dental therapist certificate, or permit application a

nonrefundable fee in the following amounts in order to administratively process an application:

(1) dentist, ~~$140~~ $308;

(2) full faculty dentist, ~~$140~~ $308;

(3) limited faculty dentist, $140;

(4) resident dentist or dental provider, $55;

(5) advanced dental therapist, $100;

(6) dental therapist, ~~$100~~ $220;

(7) dental hygienist, ~~$55~~ $115;

(8) licensed dental assistant, ~~$55; and~~ $115;

(9) dental assistant with ~~a permit~~ registration as described in Minnesota Rules, part 3100.8500, subpart 3, ~~$15.~~ $27; and

(10) guest license, $50.

Sec. 13. Minnesota Statutes 2020, section 150A.091, subdivision 5, is amended to read:

Subd. 5. **Biennial license or ~~permit~~ registration renewal fees.** Each of the following applicants shall submit with a biennial license or permit renewal application a fee as established by the board, not to exceed the following amounts:

(1) dentist or full faculty dentist, $475;

(2) dental therapist, $300;

(3) dental hygienist, $200;

(4) licensed dental assistant, $150; and

(5) dental assistant with a ~~permit~~ registration as described in Minnesota Rules, part 3100.8500, subpart 3, $24.

Sec. 14. Minnesota Statutes 2020, section 150A.091, subdivision 8, is amended to read:

Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request for issuance of a duplicate of the original license, or of an annual or biennial renewal certificate for a license or permit, a fee in the following amounts:

(1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant license, $35; and

(2) annual or biennial renewal certificates, $10~~; and~~.

~~(3) wallet-sized license and renewal certificate, $15.~~

Sec. 15. Minnesota Statutes 2020, section 150A.091, subdivision 9, is amended to read:

Subd. 9. **Licensure by credentials.** Each applicant for licensure as a dentist, dental hygienist, or dental assistant by credentials pursuant to section 150A.06, subdivisions 4 and 8, and Minnesota Rules, part 3100.1400, shall submit with the license application a fee in the following amounts:

(1) dentist, ~~$725~~ $893;

(2) dental hygienist, ~~$175; and~~ $235;

(3) dental assistant, ~~$35.~~ $71; and

(4) dental therapist, $340.

Sec. 16. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision to read:

Subd. 21. **Failure to practice with a current license.** (a) If a licensee practices without a current license and pursues reinstatement, the board may take the following administrative actions based on the length of time practicing without a current license:

(1) for under one month, the board may not assess a penalty fee;

(2) for one month to six months, the board may assess a penalty of $250;

(3) for over six months, the board may assess a penalty of $500; and

(4) for over 12 months, the board may assess a penalty of $1,000.

(b) In addition to the penalty fee, the board shall initiate the complaint process against the licensee for failure to practice with a current license for over 12 months.

Sec. 17. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision to read:

Subd. 22. **Delegating regulated procedures to an individual with a terminated license.** (a) If a dentist or dental therapist delegates regulated procedures to another dental professional who had their license terminated, the board may take the following

administrative actions against the delegating dentist or dental therapist based on the length of time they delegated regulated procedures:

(1) for under one month, the board may not assess a penalty fee;

(2) for one month to six months, the board may assess a penalty of $100;

(3) for over six months, the board may assess a penalty of $250; and

(4) for over 12 months, the board may assess a penalty of $500.

(b) In addition to the penalty fee, the board shall initiate the complaint process against a dentist or dental therapist who delegated regulated procedures to a dental professional with a terminated license for over 12 months.

Sec. 18. 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 drug administration ~~used for the treatment of alcohol or opioid dependence~~ under a prescription drug order; 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, 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, 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~~.~~; and

(13) participation in the placement of drug monitoring devices according to a prescription, protocol, or collaborative practice agreement.

Sec. 19. Minnesota Statutes 2020, section 153.16, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** The board shall issue a license to practice podiatric medicine to a person who meets the following requirements:

(a) The applicant for a license shall file a written notarized application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a podiatric medical school approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant factors.

(c) The applicant must have received a passing score on each part of the national board examinations, parts one and two, prepared and graded by the National Board of Podiatric Medical Examiners. The passing score for each part of the national board examinations, parts one and two, is as defined by the National Board of Podiatric Medical Examiners.

(d) Applicants graduating after ~~1986~~ 1990 from a podiatric medical school shall present evidence of successful completion of a residency program approved by a national accrediting podiatric medicine organization.

(e) The applicant shall appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section, including knowledge of laws, rules, and ethics pertaining to the practice of podiatric medicine. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation. Upon completion of all other application requirements, a doctor of podiatric medicine applying for a temporary military license has six months in which to comply with this subdivision.

(f) The applicant shall pay a fee established by the board by rule. The fee shall not be refunded.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee. If the applicant does not satisfy the requirements of this paragraph, the board may refuse to issue a license unless it determines that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(h) Upon payment of a fee as the board may require, an applicant who fails to pass an examination and is refused a license is entitled to reexamination within one year of the

board's refusal to issue the license. No more than two reexaminations are allowed without a new application for a license.

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

Sec. 20. **TEMPORARY REQUIREMENTS GOVERNING AMBULANCE SERVICE OPERATIONS AND THE PROVISION OF EMERGENCY MEDICAL SERVICES.**

Subdivision 1. **Application.** Notwithstanding any law to the contrary in Minnesota Statutes, chapter 144E, an ambulance service may operate according to this section, and emergency medical technicians, advanced emergency medical technicians, and paramedics may provide emergency medical services according to this section.

Subd. 2. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Advanced emergency medical technician" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5d.

(c) "Advanced life support" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 1b.

(d) "Ambulance" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 2.

(e) "Ambulance service personnel" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 3a.

(f) "Basic life support" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 4b.

(g) "Board" means the Emergency Medical Services Regulatory Board.

(h) "Emergency medical technician" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5c.

(i) "Paramedic" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5e.

(j) "Primary service area" means the area designated by the board according to Minnesota Statutes, section 144E.06, to be served by an ambulance service.

Subd. 3. **Staffing.** (a) For emergency ambulance calls in an ambulance service's primary service area, an ambulance service must staff an ambulance that provides basic life support with at least:

(1) one emergency medical technician, who must be in the patient compartment when a patient is being transported; and

(2) one individual to drive the ambulance. The driver must hold a valid driver's license from any state, must have attended an emergency vehicle driving course approved by the ambulance service, and must have completed a course on cardiopulmonary resuscitation approved by the ambulance service.

(b) For emergency ambulance calls in an ambulance service's primary service area, an ambulance service must staff an ambulance that provides advanced life support with at least:

(1) one paramedic; one registered nurse who meets the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (2); or one physician assistant who meets the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (3), and who must be in the patient compartment when a patient is being transported; and

(2) one individual to drive the ambulance. The driver must hold a valid driver's license from any state, must have attended an emergency vehicle driving course approved by the ambulance service, and must have completed a course on cardiopulmonary resuscitation approved by the ambulance service.

(c) The ambulance service director and medical director must approve the staffing of an ambulance according to this subdivision.

(d) An ambulance service staffing an ambulance according to this subdivision must immediately notify the board in writing and in a manner prescribed by the board. The notice must specify how the ambulance service is staffing its basic life support or advanced life support ambulances and the time period the ambulance service plans to staff the ambulances according to this subdivision. If an ambulance service continues to staff an ambulance according to this subdivision after the date provided to the board in its initial notice, the ambulance service must provide a new notice to the board in a manner that complies with this paragraph.

(e) If an individual serving as a driver under this subdivision commits an act listed in Minnesota Statutes, section 144E.27, subdivision 5, paragraph (a), the board may temporarily suspend or prohibit the individual from driving an ambulance or place conditions on the individual's ability to drive an ambulance using the procedures and authority in Minnesota Statutes, section 144E.27, subdivisions 5 and 6.

Subd. 4. **Use of expired emergency medications and medical supplies.** (a) If an ambulance service experiences a shortage of an emergency medication or medical supply,

ambulance service personnel may use an emergency medication or medical supply for up to six months after the emergency medication's or medical supply's specified expiration date, provided:

(1) the ambulance service director and medical director approve the use of the expired emergency medication or medical supply;

(2) ambulance service personnel use an expired emergency medication or medical supply only after depleting the ambulance service's supply of that emergency medication or medical supply that is unexpired;

(3) the ambulance service has stored and maintained the expired emergency medication or medical supply according to the manufacturer's instructions;

(4) if possible, ambulance service personnel obtain consent from the patient to use the expired emergency medication or medical supply prior to its use; and

(5) when the ambulance service obtains a supply of that emergency medication or medical supply that is unexpired, ambulance service personnel cease use of the expired emergency medication or medical supply and instead use the unexpired emergency medication or medical supply.

(b) Before approving the use of an expired emergency medication, an ambulance service director and medical director must consult with the Board of Pharmacy regarding the safety and efficacy of using the expired emergency medication.

(c) An ambulance service must keep a record of all expired emergency medications and all expired medical supplies used and must submit that record in writing to the board in a time and manner specified by the board. The record must list the specific expired emergency medications and medical supplies used and the time period during which ambulance service personnel used the expired emergency medication or medical supply.

Subd. 5. **Provision of emergency medical services after certification expires.** (a) At the request of an emergency medical technician, advanced emergency medical technician, or paramedic, and with the approval of the ambulance service director, an ambulance service medical director may authorize the emergency medical technician, advanced emergency medical technician, or paramedic to provide emergency medical services for the ambulance service for up to three months after the certification of the emergency medical technician, advanced emergency medical technician, or paramedic expires.

(b) An ambulance service must immediately notify the board each time its medical director issues an authorization under paragraph (a). The notice must be provided in writing

and in a manner prescribed by the board and must include information on the time period each emergency medical technician, advanced emergency medical technician, or paramedic will provide emergency medical services according to an authorization under this subdivision; information on why the emergency medical technician, advanced emergency medical technician, or paramedic needs the authorization; and an attestation from the medical director that the authorization is necessary to help the ambulance service adequately staff its ambulances.

Subd. 6. **Reports.** The board must provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over the board regarding actions taken by ambulance services according to subdivisions 3, 4, and 5. The board must submit reports by June 30, September 30, and December 31 of 2022; and by March 31, June 30, September 30, and December 31 of 2023. Each report must include the following information:

(1) for each ambulance service staffing basic life support or advanced life support ambulances according to subdivision 3, the primary service area served by the ambulance service, the number of ambulances staffed according to subdivision 3, and the time period the ambulance service has staffed and plans to staff the ambulances according to subdivision 3;

(2) for each ambulance service that authorized the use of an expired emergency medication or medical supply according to subdivision 4, the expired emergency medications and medical supplies authorized for use and the time period the ambulance service used each expired emergency medication or medical supply; and

(3) for each ambulance service that authorized the provision of emergency medical services according to subdivision 5, the number of emergency medical technicians, advanced emergency medical technicians, and paramedics providing emergency medical services under an expired certification and the time period each emergency medical technician, advanced emergency medical technician, or paramedic provided and will provide emergency medical services under an expired certification.

Subd. 7. **Expiration.** This section expires January 1, 2024.

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

Sec. 21. **REPEALER.**

Minnesota Statutes 2020, section 150A.091, subdivisions 3, 15, and 17, are repealed.

ARTICLE 6
PRESCRIPTION DRUGS

Section 1. Minnesota Statutes 2020, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. **Filing.** For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing must include the health plan's prescription drug formulary. Proposed revisions to the health plan's prescription drug formulary must be filed with the commissioner no later than August 1 of the application year. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Sec. 2. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 1, is amended to read:

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

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(l) "NCPDP Real-Time Prescription Benefit Standard" means the most recent National Council for Prescription Drug Programs Real-Time Prescription Benefit Standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(2) of the Social Security Act and regulations adopted under it.

~~(l)~~ (m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs SCRIPT Standard, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

~~(m)~~ (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

~~(n)~~ (p) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(o)~~ (q) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(p)~~ (r) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(s) "Real-time prescription benefit tool" means a tool that is capable of being integrated into a prescriber's e-prescribing system and that provides a prescriber with up-to-date and patient-specific formulary and benefit information at the time the prescriber submits a prescription.

Sec. 3. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

(f) Group purchasers and pharmacy benefit managers must use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that, at a minimum, notifies a prescriber:

(1) if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit manager;

(2) if a prescribed drug is included on the formulary or preferred drug list of the patient's group purchaser or pharmacy benefit manager;

(3) of any patient cost-sharing for the prescribed drug;

(4) if prior authorization is required for the prescribed drug; and

(5) of a list of any available alternative drugs that are in the same class as the drug originally prescribed and for which prior authorization is not required.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 4. Minnesota Statutes 2020, section 62J.84, as amended by Laws 2021, chapter 30, article 3, sections 5 to 9, is amended to read:

62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.

Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price Transparency Act."

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

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) an original, new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title ~~45~~ 42, section 262(a)(c).

(d) "Commissioner" means the commissioner of health.

(e) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the Food and Drug Administration (FDA)-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

~~(e)~~ (f) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(h) "National Drug Code" means the three-segment code maintained by the FDA that includes a labeler code, a product code, and a package code for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits so that each segment contains the specified number of digits.

~~(g)~~ (i) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration for which no previous wholesale acquisition cost has been established for comparison.

~~(h)~~ (j) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

~~(i)~~ (k) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

~~(j)~~ (l) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(m) "Rebate" means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective financial reconciliations including reconciliations that also reflect other contractual arrangements, or by any other method. Rebate does not mean a bona fide service fee, as the term is defined in Code of Federal Regulations, title 42, section 447.502.

(n) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the 30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the name, description, and price of the drug and the net increase, expressed as a percentage~~;~~, with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase when it was approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years;

(5) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the previous 12-month period;

(7) the total rebate payable amount accrued for the prescription drug during the previous 12-month period;

~~(6)~~ (8) the total sales revenue for the prescription drug during the previous 12-month period;

~~(7)~~ (9) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

~~(8)~~ (10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

~~(9)~~ (11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

~~(10)~~ (12) the patent expiration date of the prescription drug if it is under patent;

~~(11)~~ (13) the name and location of the company that manufactured the drug; ~~and~~

~~(12)~~ (14) if a brand name prescription drug, the ten highest prices paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(15) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description of the drug, with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size

~~(1)~~ (2) the price of the prescription drug;

~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning January 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information

described in paragraph (b) for each newly acquired prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for a newly acquired brand name drug where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in price over the previous 24-month period; and

(2) for a newly acquired generic or biosimilar drug where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall submit to the commissioner no later than 60 days after the acquiring manufacturer begins to sell the newly acquired drug, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description of the drug, with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size

~~(1)~~ (2) the price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;

~~(2)~~ (3) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;

~~(3)~~ (4) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;

~~(4)~~ (5) the price of the prescription drug for the previous five years;

~~(5)~~ (6) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the manufacturer's drug; and

~~(6)~~ (7) the patent expiration date of the drug if it is under patent.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, and 5.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of

Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the manufacturers to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and manufacturers.

Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to submit timely reports or notices as required by this section;

(2) failing to provide information required under this section; or

(3) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and 5.

Sec. 5. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section and section 62J.841, the terms defined in this subdivision have the meanings given.

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) an original, new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title 45, section 262(a)(c).

(d) "Commissioner" means the commissioner of health.

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title 45, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252, but does not include an entity required to be licensed under that section solely because the entity repackages or relabels drugs.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

Sec. 6. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

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

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) an original, new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title 45, section 262(a)(c).

(d) "Commissioner" means the commissioner of health.

(e) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

~~(e)~~ (f) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title 45, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

~~(g)~~ (h) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration for which no previous wholesale acquisition cost has been established for comparison.

~~(h)~~ (i) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(j) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

(k) "Pharmacy benefits manager (PBM)" means an entity licensed to act as a pharmacy benefits manager under section 62W.03.

~~(i)~~ (l) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

~~(j)~~ (m) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(n) "Pricing Unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

(o) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager, wholesale drug distributor, or any other entity required to submit data under section 62J.84.

(p) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities other than a consumer or patient in the state.

Sec. 7. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the manufacturers of those prescription drugs; ~~and~~

(2) information reported to the commissioner under subdivisions 3, 4, and 5~~.~~; and

(3) information reported to the commissioner under section 62J.841, subdivision 2.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b), subject to section 62J.841, subdivision 2, paragraph (e); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended, subject to section 62J.841, subdivision 2, paragraph (e). If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 8. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 9. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section and section 62J.841; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section and section 62J.841.

(b) The commissioner may consult with representatives of the manufacturers to establish a standard format for reporting information under this section and section 62J.841 and may

use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and manufacturers.

Sec. 10. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

Sec. 11. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to submit timely reports or notices as required by this section and section 62J.841;

(2) failing to provide information required under this section and section 62J.841; ~~or~~

(3) providing inaccurate or incomplete information under this section and section 62J.841; or

(4) failing to comply with section 62J.481, subdivisions 2, paragraph (e), and 4.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section and section 62J.841 as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section and section 62J.481 upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section and section 62J.841 shall be deposited in the health care access fund.

Sec. 12. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Sec. 13. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section and section 62J.841, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state, health carriers, and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state, health carriers, and other payers in the management of pharmaceutical costs and limiting formulary changes due to prescription drug cost increases during a coverage year.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and 5, and section 62J.841.

Sec. 14. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14.

Sec. 15. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2023, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 11, 12, 13, and 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 5 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment period process.

(b) No sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via e-mail, reporting entities registered with the department of the requirement to report under subdivisions 11, 12, 13, and 14.

(c) No more than 500 prescription drugs may be designated as having a substantial public interest in any one notice.

Sec. 16. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivisions 3 or 5 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

(11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(12) the patent expiration date of the prescription drug if it is under patent;

(13) the name and location of the company that manufactured the drug;

(14) if a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within the 12-month period prior to the date of the notification to report, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 17. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report in the form and manner prescribed by the commissioner the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug, including ingredient cost, dispensing fee, and administrative fees, during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

Sec. 18. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **Pharmacy benefit manager (PBM) prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a PBM as defined in section 62W.02, subdivision 14, must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount or both accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 19. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a wholesaler must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesaler by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

(c) The wholesaler may submit any documentation necessary to support the information reported under this subdivision.

Sec. 20. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirement.** Beginning January 1, 2023, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 21. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

Sec. 22. **[62J.841] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY DEVELOPMENT AND PRICE STABILITY.**

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

(b) "Average wholesale price" means the customary reference price for sales by a drug wholesaler to a retail pharmacy, as established and published by the manufacturer.

(c) "National drug code" means the numerical code maintained by the United States Food and Drug Administration and includes the label code, product code, and package code.

(d) "Unit" has the meaning given in United States Code, title 42, section 1395w-3a(b)(2).

(e) "Wholesale acquisition cost" has the meaning given in United States Code, title 42, section 1395w-3a(c)(6)(B).

Subd. 2. **Price reporting.** (a) Beginning July 31, 2023, and by July 31 each year thereafter, a manufacturer must report to the commissioner the information in paragraph (b) for every drug with a wholesale acquisition cost of $100 or more for a 30-day supply or for a course of treatment lasting less than 30 days, as applicable to the next calendar year.

(b) A manufacturer shall report a drug's:

(1) national drug code, labeler code, and the manufacturer name associated with the labeler code;

(2) brand name, if applicable;

(3) generic name, if applicable;

(4) wholesale acquisition cost for one unit;

(5) measure that constitutes a wholesale acquisition cost unit;

(6) average wholesale price; and

(7) status as brand name or generic.

(c) The effective date of the information described in paragraph (b) must be included in the report to the commissioner.

(d) A manufacturer must report the information described in this subdivision in the form and manner specified by the commissioner.

(e) Information reported under this subdivision is classified as public data not on individuals, as defined in section 13.02, subdivision 14, and must not be classified by the manufacturer as trade secret information, as defined in section 13.37, subdivision 1, paragraph (b).

(f) A manufacturer's failure to report the information required by this subdivision is grounds for disciplinary action under section 151.071, subdivision 2.

Subd. 3. **Public posting of prescription drug price information.** By October 1 of each year, beginning October 1, 2023, the commissioner must post the information reported under subdivision 2 on the department website, as required by section 62J.84, subdivision 6.

Subd. 4. **Price change.** (a) If a drug subject to price reporting under subdivision 2 is included in the formulary of a health plan submitted to and approved by the commissioner of commerce for the next calendar year under section 62A.02, subdivision 1, the manufacturer

may increase the wholesale acquisition cost of the drug for the next calendar year only after providing the commissioner with at least 90 days' written notice.

(b) A manufacturer's failure to meet the requirements of paragraph (a) is grounds for disciplinary action under section 151.071, subdivision 2.

Sec. 23. **[62J.841] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following definitions apply.

Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items, reported by the United States Department of Labor, Bureau of Labor Statistics, or its successor or, if the index is discontinued, an equivalent index reported by a federal authority or, if no such index is reported, "Consumer Price Index" means a comparable index chosen by the Bureau of Labor Statistics.

Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription drug for which any exclusive marketing rights granted under the Federal Food, Drug, and Cosmetic Act; section 351 of the federal Public Health Service Act; and federal patent law have expired, including any drug-device combination product for the delivery of a generic drug.

Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning provided in United States Code, title 42, section 1395w-3a.

Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in section 151.441, subdivision 14.

Sec. 24. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state.

Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this section when:

(1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

(i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar year; or

(ii) 40 percent of the wholesale acquisition cost over the immediately preceding three calendar years; and

(2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:

(i) a 30-day supply of the drug; or

(ii) a course of treatment lasting less than 30 days.

Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy by the manufacturer of the drug.

Sec. 25. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

Any manufacturer that sells, distributes, delivers, or offers for sale any generic or off-patent drug in the state is required to maintain a registered agent and office within the state.

Sec. 26. **[62J.844] ENFORCEMENT.**

Subdivision 1. **Notification.** The commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit, except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit other than an entity under contract with the Department of Human Services, shall notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board of Pharmacy of any price increase in violation of section 62J.842.

Subd. 2. **Submission of drug cost statement and other information by manufacturer; investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to the attorney general. The statement must:

(1) itemize the cost components related to production of the drug;

(2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

(3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

(b) The attorney general may investigate whether a violation of section 62J.842 has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

(1) compelling the manufacturer of a generic or off-patent drug to:

(i) provide the drug cost statement required under subdivision 2, paragraph (a); and

(ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

(2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

(3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

(4) requiring the manufacturer to repay to all consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

(5) notwithstanding section 16A.151, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4), requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs;

(6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

(7) providing for the attorney general's recovery of its costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

(8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 must be considered a separate violation.

Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of this section is for the benefit of the public.

Sec. 27. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR OFF-PATENT DRUGS FOR SALE.**

Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited from withdrawing that drug from sale or distribution within this state for the purpose of avoiding the prohibition on excessive price increases under section 62J.842.

Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution within the state shall provide a written notice of withdrawal to the Board of Pharmacy and the attorney general at least 180 days prior to the withdrawal.

Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of $500,000 on any manufacturer of a generic or off-patent drug that it determines has failed to comply with the requirements of this section.

Sec. 28. **[62J.846] SEVERABILITY.**

If any provision of sections 62J.841 to 62J.845 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.841 to 62J.845 that can be given effect without the invalid provision or application.

Sec. 29. **[62J.85] CITATION.**

Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

Sec. 30. **[62J.86] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 62J.85 to 62J.95, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Prescription Drug Affordability Advisory Council established under section 62J.88.

Subd. 3. **Biologic.** "Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under Code of Federal Regulations, title 42, section 447.502.

Subd. 4. **Biosimilar.** "Biosimilar" has the meaning provided in section 62J.84, subdivision 2, paragraph (b).

Subd. 5. **Board.** "Board" means the Prescription Drug Affordability Board established under section 62J.87.

Subd. 6. **Brand name drug.** "Brand name drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (c).

Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84, subdivision 2, paragraph (e).

Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6, and includes pharmacy benefit managers as defined in section 62W.02, subdivision 15.

Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

(1) engages in the manufacture of a prescription drug product or enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; and

(2) sets or changes the wholesale acquisition cost of the prescription drug product it manufacturers or markets.

Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC" has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

Sec. 31. **[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.**

Subdivision 1. **Establishment.** The commissioner of commerce shall establish the Prescription Drug Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, pharmacies, and other health care system stakeholders from unaffordable costs of certain prescription drugs.

Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine members appointed as follows:

(1) seven voting members appointed by the governor;

(2) one nonvoting member appointed by the majority leader of the senate; and

(3) one nonvoting member appointed by the speaker of the house.

(b) All members appointed must have knowledge and demonstrated expertise in pharmaceutical economics and finance or health care economics and finance. A member must not be an employee of, a board member of, or a consultant to a manufacturer or trade association for manufacturers or a pharmacy benefit manager or trade association for pharmacy benefit managers.

(c) Initial appointments must be made by January 1, 2023.

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial appointees shall serve staggered terms of two, three, or four years as determined by lot by the secretary of state. A board member shall serve no more than two consecutive terms.

(b) A board member may resign at any time by giving written notice to the board.

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor. The acting chair shall convene the first meeting of the board.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for one year.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and other staff, who shall serve in the unclassified service. The executive director must have knowledge and demonstrated expertise in pharmacoeconomics, pharmacology, health policy, health services research, medicine, or a related field or discipline. The board may employ or contract for professional and technical assistance as the board deems necessary to perform the board's duties.

(b) The attorney general shall provide legal services to the board.

Subd. 6. **Compensation.** The board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least every three months to review prescription drug product information submitted to the board under section 62J.90. If there are no pending submissions, the chair of the board may cancel or postpone the required meeting. The board may meet in closed session when reviewing proprietary information as determined under the standards developed in accordance with section 62J.91, subdivision 4.

(b) The board shall announce each public meeting at least two weeks prior to the scheduled date of the meeting. Any materials for the meeting must be made public at least one week prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

Sec. 32. **[62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The governor shall appoint a 12-member stakeholder advisory council to provide advice to the board on drug cost issues and to represent stakeholders' views. The members of the advisory council shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: the pharmaceutical business; practice of medicine; patient perspectives; health care cost trends and drivers; clinical and health services research; and the health care marketplace.

Subd. 2. **Membership.** The council's membership shall consist of the following:

(1) two members representing patients and health care consumers;

(2) two members representing health care providers;

(3) one member representing health plan companies;

(4) two members representing employers, with one member representing large employers and one member representing small employers;

(5) one member representing government employee benefit plans;

(6) one member representing pharmaceutical manufacturers;

(7) one member who is a health services clinical researcher;

(8) one member who is a pharmacologist; and

(9) one member representing the commissioner of health with expertise in health economics.

Subd. 3. **Terms.** (a) The initial appointments to the advisory council must be made by January 1, 2023. The initial appointed advisory council members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, the advisory council members shall serve four-year terms.

(b) Removal and vacancies of advisory council members are governed by section 15.059.

Subd. 4. **Compensation.** Advisory council members may be compensated according to section 15.059.

Subd. 5. **Meetings.** Meetings of the advisory council are subject to chapter 13D. The advisory council shall meet publicly at least every three months to advise the board on drug cost issues related to the prescription drug product information submitted to the board under section 62J.90.

Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 33. **[62J.89] CONFLICTS OF INTEREST.**

Subdivision 1. **Definition.** (a) For purposes of this section, "conflict of interest" means a financial or personal association that has the potential to bias or have the appearance of biasing a person's decisions in matters related to the board or the advisory council, or in the conduct of the board's or council's activities.

(b) A conflict of interest includes any instance in which a person or a person's immediate family member has received or could receive a direct or indirect financial benefit of any amount deriving from the result or findings of a decision or determination of the board.

(c) For purposes of this section, a person's immediate family member includes a spouse, parent, child, or other legal dependent, or an in-law of any of the preceding individuals.

(d) For purposes of this section, a financial benefit includes honoraria, fees, stock, the value of stock holdings, and any direct financial benefit deriving from the finding of a review conducted under sections 62J.85 to 62J.95.

(e) Ownership of securities is not a conflict of interest if the securities are: (1) part of a diversified mutual or exchange traded fund; or (2) in a tax-deferred or tax-exempt retirement account that is administered by an independent trustee.

Subd. 2. **General.** (a) A board or advisory council member, board staff member, or third-party contractor must disclose any conflicts of interest to the appointing authority or the board prior to the acceptance of an appointment, an offer of employment, or a contractual agreement. The information disclosed must include the type, nature, and magnitude of the interests involved.

(b) A board member, board staff member, or third-party contractor with a conflict of interest relating to any prescription drug product under review must recuse themselves from any discussion, review, decision, or determination made by the board relating to the prescription drug product.

(c) Any conflict of interest must be disclosed in advance of the first meeting after the conflict is identified or within five days after the conflict is identified, whichever is earlier.

Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are prohibited from accepting gifts, bequeaths, or donations of services or property that raise the specter of a conflict of interest or have the appearance of injecting bias into the activities of the board.

Sec. 34. **[62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION TO CONDUCT COST REVIEW.**

Subdivision 1. **Drug price information from the commissioner of health and other sources.** (a) The commissioner of health shall provide to the board the information reported to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5. The commissioner shall provide this information to the board within 30 days of the date the information is received from drug manufacturers.

(b) The board shall subscribe to one or more prescription drug pricing files, such as Medispan or FirstDatabank, or as otherwise determined by the board.

Subd. 2. **Identification of certain prescription drug products.** (a) The board, in consultation with the advisory council, shall identify the following prescription drug products:

(1) brand name drugs or biologics for which the WAC increases by more than ten percent or by more than $10,000 during any 12-month period or course of treatment if less than 12 months, after adjusting for changes in the consumer price index (CPI);

(2) brand name drugs or biologics introduced at a WAC of $30,000 or more per calendar year or per course of treatment;

(3) biosimilar drugs introduced at a WAC that is not at least 15 percent lower than the referenced brand name biologic at the time the biosimilar is introduced; and

(4) generic drugs for which the WAC:

(i) is $100 or more, after adjusting for changes in the CPI, for:

(A) a 30-day supply lasting a patient for a period of 30 consecutive days based on the recommended dosage approved for labeling by the United States Food and Drug Administration (FDA);

(B) a supply lasting a patient for fewer than 30 days based on recommended dosage approved for labeling by the FDA; or

(C) one unit of the drug if the labeling approved by the FDA does not recommend a finite dosage; and

(ii) has increased by 200 percent or more during the immediate preceding 12-month period, as determined by the difference between the resulting WAC and the average of the WAC reported over the preceding 12 months, after adjusting for changes in the CPI.

(b) The board, in consultation with the advisory council, shall identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.

(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 4.

Subd. 3. **Determination to proceed with review.** (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.

(b) The board shall consider requests by the public for the board to proceed with a cost review of any prescription drug product identified under this section.

(c) If there is no consensus among the members of the board on whether or not to initiate a cost review of a prescription drug product, any member of the board may request a vote to determine whether or not to review the cost of the prescription drug product.

Sec. 35. **[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.**

Subdivision 1. **General.** Once the board decides to proceed with a cost review of a prescription drug product, the board shall conduct the review and make a determination as to whether appropriate utilization of the prescription drug under review, based on utilization that is consistent with the United States Food and Drug Administration (FDA) label or standard medical practice, has led or will lead to affordability challenges for the state health care system or for patients.

Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product, the board may consider the following factors:

(1) the price at which the prescription drug product has been and will be sold in the state;

(2) the average monetary price concession, discount, or rebate the manufacturer provides to a group purchaser in this state as reported by the manufacturer and the group purchaser, expressed as a percent of the WAC for the prescription drug product under review;

(3) the price at which therapeutic alternatives have been or will be sold in the state;

(4) the average monetary price concession, discount, or rebate the manufacturer provides or is expected to provide to a group purchaser or group purchasers in the state for therapeutic alternatives;

(5) the cost to group purchasers based on patient access consistent with the FDA-labeled indications;

(6) the impact on patient access resulting from the cost of the prescription drug product relative to insurance benefit design;

(7) the current or expected dollar value of drug-specific patient access programs supported by manufacturers;

(8) the relative financial impacts to health, medical, or other social services costs that can be quantified and compared to baseline effects of existing therapeutic alternatives;

(9) the average patient co-pay or other cost-sharing for the prescription drug product in the state;

(10) any information a manufacturer chooses to provide; and

(11) any other factors as determined by the board.

Subd. 3. **Further review factors.** If, after considering the factors described in subdivision 2, the board is unable to determine whether a prescription drug product will produce or has produced an affordability challenge, the board may consider:

(1) manufacturer research and development costs, as indicated on the manufacturer's federal tax filing for the most recent tax year, in proportion to the manufacturer's sales in the state;

(2) the portion of direct-to-consumer marketing costs eligible for favorable federal tax treatment in the most recent tax year that is specific to the prescription drug product under review, multiplied by the ratio of total manufacturer in-state sales to total manufacturer sales in the United States for the product under review;

(3) gross and net manufacturer revenues for the most recent tax year;

(4) any information and research related to the manufacturer's selection of the introductory price or price increase, including but not limited to:

(i) life cycle management;

(ii) market competition and context; and

(iii) projected revenue; and

(5) any additional factors determined by the board to be relevant.

Subd. 4. **Public data; proprietary information.** (a) Any submission made to the board related to a drug cost review must be made available to the public with the exception of information determined by the board to be proprietary.

(b) The board shall establish the standards for the information to be considered proprietary under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened consideration of proprietary information for submissions for a cost review of a drug that is not yet approved by the FDA.

(c) Prior to the board establishing the standards under paragraph (b), the public must be provided notice and the opportunity to submit comments.

Sec. 36. **[62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.**

Subdivision 1. **Upper payment limit.** (a) In the event the board finds that the spending on a prescription drug product reviewed under section 62J.91 creates an affordability challenge for the state health care system or for patients, the board shall establish an upper payment limit after considering:

(1) the cost of administering the drug;

(2) the cost of delivering the drug to consumers;

(3) the range of prices at which the drug is sold in the United States according to one or more pricing files accessed under section 62J.90, subdivision 1, and the range at which pharmacies are reimbursed in Canada; and

(4) any other relevant pricing and administrative cost information for the drug.

(b) The upper payment limit must apply to all public and private purchases, payments, and payer reimbursements for the prescription drug products received by an individual in the state in person, by mail, or by other means.

Subd. 2. **Noncompliance.** (a) The failure of an entity to comply with an upper payment limit established by the board under this section shall be referred to the Office of the Attorney General.

(b) If the Office of the Attorney General finds that an entity was noncompliant with the upper payment limit requirements, the attorney general may pursue remedies consistent with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

(c) An entity that obtains price concessions from a drug manufacturer that result in a lower net cost to the stakeholder than the upper payment limit established by the board must not be considered to be in noncompliance.

(d) The Office of the Attorney General may provide guidance to stakeholders concerning activities that could be considered noncompliant.

Subd. 3. **Appeals.** (a) Persons affected by a decision of the board may request an appeal of the board's decision within 30 days of the date of the decision. The board shall hear the appeal and render a decision within 60 days of the hearing.

(b) All appeal decisions are subject to judicial review in accordance with chapter 14.

Sec. 37. **[62J.93] REPORTS.**

Beginning March 1, 2023, and each March 1 thereafter, the board shall submit a report to the governor and legislature on general price trends for prescription drug products and the number of prescription drug products that were subject to the board's cost review and analysis, including the result of any analysis and the number and disposition of appeals and judicial reviews.

Sec. 38. **[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.**

(a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare Part D plans may choose to exceed the upper payment limit established by the board under section 62J.92.

(b) Providers who dispense and administer drugs in the state must bill all payers no more than the upper payment limit without regard to whether or not an ERISA plan or Medicare Part D plan chooses to reimburse the provider in an amount greater than the upper payment limit established by the board.

(c) For purposes of this section, an ERISA plan or group health plan is an employee welfare benefit plan established or maintained by an employer or an employee organization, or both, that provides employer sponsored health coverage to employees and the employee's dependents and is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Sec. 39. **[62J.95] SEVERABILITY.**

If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.85 to 62J.94 that can be given effect without the invalid provision or application.

Sec. 40. **[62Q.1842] PROHIBITION ON USE OF STEP THERAPY FOR ANTIRETROVIRAL DRUGS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3, and includes health coverage provided by a managed care plan or a county-based purchasing plan participating in a public program under chapter 256B or 256L or an integrated health partnership under section 256B.0755.

(c) "Step therapy protocol" has the meaning given in section 62Q.184.

Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that covers antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis and postexposure prophylaxis, must not limit or exclude coverage for the antiretroviral drugs by requiring prior authorization or by requiring an enrollee to follow a step therapy protocol.

Sec. 41. **[62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more than $25 per one-month supply for each prescription drug and to no more than $50 per month in total for all related medical supplies. Coverage under this section must not be subject to any deductible.

(b) If application of this section before an enrollee has met their plan's deductible would result in health savings account ineligibility under United States Code, title 26, section 223, then this section must apply to that specific prescription drug or related medical supply only after the enrollee has met their plan's deductible.

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

(b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors.

(c) "Cost-sharing" means co-payments and coinsurance.

(d) "Related medical supplies" means syringes, insulin pens, insulin pumps, epinephrine auto-injectors, test strips, glucometers, continuous glucose monitors, and other medical supply items necessary to effectively and appropriately administer a prescription drug prescribed to treat a chronic disease.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 42. **[62Q.524] COVERAGE FOR DRUGS TO PREVENT THE ACQUISITION OF HUMAN IMMUNODEFICIENCY VIRUS.**

(a) A health plan that provides prescription drug coverage must provide coverage in accordance with this section for:

(1) any antiretroviral drug approved by the United States Food and Drug Administration (FDA) for preventing the acquisition of human immunodeficiency virus (HIV) that is prescribed, dispensed, or administered by a pharmacist who meets the requirements described in section 151.37, subdivision 17; and

(2) any laboratory testing necessary for therapy that uses the drugs described in clause (1) that is ordered, performed, and interpreted by a pharmacist who meets the requirements described in section 151.37, subdivision 17.

(b) A health plan must provide the same terms of prescription drug coverage for drugs to prevent the acquisition of HIV that are prescribed or administered by a pharmacist if the pharmacist meets the requirements described in section 151.37, subdivision 17, as would apply had the drug been prescribed or administered by a physician, physician assistant, or advanced practice registered nurse. The health plan may require pharmacists or pharmacies to meet reasonable medical management requirements when providing the services described in paragraph (a) if other providers are required to meet the same requirements.

(c) A health plan must reimburse an in-network pharmacist or pharmacy for the drugs and testing described in paragraph (a) at a rate equal to the rate of reimbursement provided to a physician, physician assistant, or advanced practice registered nurse if providing similar services.

(d) A health plan is not required to cover the drugs and testing described in paragraph (a) if provided by a pharmacist or pharmacy that is out-of-network unless the health plan covers similar services provided by out-of-network providers. A health plan must ensure that the health plan's provider network includes in-network pharmacies that provide the services described in paragraph (a).

Sec. 43. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a single calendar quarter.

(d) "Formulary" means a list of prescription drugs developed by clinical and pharmacy experts that represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company.

For purposes of this paragraph, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of the plan's enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make the plan's formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days before annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from the plan's formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from the plan's formulary that have been deemed unsafe by the Food and Drug Administration; that have been withdrawn by

either the Food and Drug Administration or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

(e) The state employee group insurance program and coverage offered through that program are exempt from the requirements of this subdivision.

Subd. 4. **Not severable.** (a) The provisions of this section are not severable from the amendments and enactments in this act to sections 62A.02, subdivision 1; 62J.84, subdivisions 2, 6, 7, 8, and 9; 62J.841; and 151.071, subdivision 2.

(b) If any amendment or enactment listed in paragraph (a) or its application to any individual, entity, or circumstance is found to be void for any reason, this section is also void.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 44. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

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

(b) "Biological product" has the meaning given in section 151.01, subdivision 40.

(c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01, subdivision 43.

(d) "Interchangeable biological product" has the meaning given in section 151.01, subdivision 41.

(e) "Reference biological product" has the meaning given in section 151.01, subdivision 44.

Subd. 2. **Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products.** (a) Notwithstanding paragraph (b), a pharmacy benefit manager or health carrier must not require or demonstrate a preference for a reference biological product administered to a patient by a physician or health care provider or any product that is biosimilar to the reference biological product or an interchangeable biological product administered to a patient by a physician or health care provider.

(b) If a pharmacy benefit manager or health carrier elects coverage of a product listed in paragraph (a), and there are two or less biosimilar products available relative to the

reference product, the pharmacy benefit manager or health carrier must elect equivalent coverage for all of the products that are biosimilar to the reference biological product or interchangeable biological product.

(c) If a pharmacy benefit manager or health carrier elects coverage of a product listed in paragraph (a), and there are greater than two biosimilar products available relative to the reference product, the pharmacy benefit manager or health carrier must elect preferential coverage for all of the products that are biosimilar to the reference biological or interchangeable biological products.

(d) A pharmacy benefit manager or health carrier must not impose limits on access to a product required to be covered under paragraph (b) that are more restrictive than limits imposed on access to a product listed in paragraph (a), or that otherwise have the same effect as giving preferred status to a product listed in paragraph (a) over the product required to be covered under paragraph (b).

(e) This section only applies to new administrations of a reference biological product. Nothing in this section requires switching from a prescribed reference biological product for a patient on an active course of treatment.

Subd. 3. **Exemption.** The state employee group insurance program, and coverage offered through that program, are exempt from the requirements of this section.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 45. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

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

(b) "Affiliated pharmacy" means a pharmacy in which a pharmacy benefit manager or health carrier has an ownership interest either directly or indirectly, or through an affiliate or subsidiary.

(c) "Clinician-administered drug" means an outpatient prescription drug other than a vaccine that:

(1) cannot reasonably be self-administered by the patient to whom the drug is prescribed or by an individual assisting the patient with self-administration; and

(2) is typically administered:

(i) by a health care provider authorized to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

Subd. 2. **Prohibition on requiring coverage as a pharmacy benefit.** A pharmacy benefit manager or health carrier shall not require that a clinician-administered drug or the administration of a clinician-administered drug be covered as a pharmacy benefit.

Subd. 3. **Enrollee choice.** A pharmacy benefit manager or health carrier:

(1) shall permit an enrollee to obtain a clinician-administered drug from a health care provider authorized to administer the drug, or a pharmacy;

(2) shall not interfere with the enrollee's right to obtain a clinician-administered drug from their provider or pharmacy of choice, and shall not offer financial or other incentives to influence the enrollee's choice of a provider or pharmacy;

(3) shall not require clinician-administered drugs to be dispensed by a pharmacy selected by the pharmacy benefit manager or health carrier; and

(4) shall not limit or exclude coverage for a clinician-administered drug when it is not dispensed by a pharmacy selected by the pharmacy benefit manager or health carrier, if the drug would otherwise be covered.

Subd. 4. **Cost-sharing and reimbursement.** A pharmacy benefit manager or health carrier:

(1) may impose coverage or benefit limitations on an enrollee who obtains a clinician-administered drug from a health care provider authorized to administer the drug, or a pharmacy, only if these limitations would also be imposed were the drug to be obtained from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or health carrier; and

(2) may impose cost-sharing requirements on an enrollee who obtains a clinician-administered drug from a health care provider authorized to administer the drug, or a pharmacy, only if these requirements would also be imposed were the drug to be obtained from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or health carrier.

Subd. 5. **Other requirements.** A pharmacy benefit manager or health carrier:

(1) shall not require or encourage the dispensing of a clinician-administered drug to an enrollee in a manner that is inconsistent with the supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act, United States Code, title 21, section 360eee, et seq.;

(2) shall not require a specialty pharmacy to dispense a clinician-administered medication directly to a patient with the intention that the patient will transport the medication to a health care provider for administration; and

(3) may offer, but shall not require:

(i) the use of a home infusion pharmacy to dispense or administer clinician-administered drugs to enrollees; and

(ii) the use of an infusion site external to the enrollee's provider office or clinic.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 46. Minnesota Statutes 2020, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed advanced practice registered nurse, or licensed physician assistant. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered hormonal contraceptives, nicotine replacement medications, or opiate antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37, subdivision 17.

Sec. 47. 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, 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, 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~~.~~;

(13) prescribing, dispensing, and administering drugs for preventing the acquisition of human immunodeficiency virus (HIV) if the pharmacist meets the requirements under section 151.37, subdivision 17; and

(14) ordering, conducting, and interpreting laboratory tests necessary for therapies that use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements under section 151.37, subdivision 17.

Sec. 48. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 43. **Biosimilar product.** "Biosimilar product" or "interchangeable biologic product" means a biological product that the United States Food and Drug Administration has licensed and determined to be biosimilar under United States Code, title 42, section 262(i)(2).

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 49. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 44. **Reference biological product.** "Reference biological product" means the single biological product for which the United States Food and Drug Administration has approved an initial biological product license application, against which other biological products are evaluated for licensure as biosimilar products or interchangeable biological products.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 50. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 51. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

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

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

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that 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; (ii) conduct that 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 (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that 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. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

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

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

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

state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

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

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

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

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

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

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

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

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

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

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

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

(17) fee splitting, including without limitation:

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

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

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price

for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

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

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

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

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

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

(i) 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;

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

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

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

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed

or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

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

(25) for a drug manufacturer, failure to comply with section 62J.841.

Sec. 52. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

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

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

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that 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; (ii) conduct that 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 (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that 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. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

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

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

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

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

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

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

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of

a patient; or pharmacy practice that is professionally incompetent, in that it 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;

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

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

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

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

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

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

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

(17) fee splitting, including without limitation:

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

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

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

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

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

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

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

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

(i) 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;

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

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

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

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

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

(25) for a manufacturer, a violation of section 62J.842 or 62J.845.

Sec. 53. Minnesota Statutes 2021 Supplement, section 151.335, is amended to read:

151.335 DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH TEMPERATURE REQUIREMENTS.

In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a mail order or specialty pharmacy that employs the United States Postal Service or other common carrier to deliver a filled prescription directly to a patient must ensure that the drug is delivered in compliance with temperature requirements established by the manufacturer of the drug. The methods used to ensure compliance must include but are not limited to enclosing in each medication's packaging a device recognized by the United States Pharmacopeia by which the patient can easily detect improper storage or temperature variations. The pharmacy must develop written policies and procedures that are consistent with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized

standards issued by standard-setting or accreditation organizations recognized by the board through guidance. The policies and procedures must be provided to the board upon request.

Sec. 54. Minnesota Statutes 2020, section 151.37, is amended by adding a subdivision to read:

Subd. 17. **Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized to prescribe and administer drugs to prevent the acquisition of human immunodeficiency virus (HIV) in accordance with this subdivision.

(b) By January 1, 2023, the board of pharmacy shall develop a standardized protocol for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing the protocol, the board may consult with community health advocacy groups, the board of medical practice, the board of nursing, the commissioner of health, professional pharmacy associations, and professional associations for physicians, physician assistants, and advanced practice registered nurses.

(c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the pharmacist must successfully complete a training program specifically developed for prescribing drugs for preventing the acquisition of HIV that is offered by a college of pharmacy, a continuing education provider that is accredited by the Accreditation Council for Pharmacy Education, or a program approved by the board. To maintain authorization to prescribe, the pharmacist shall complete continuing education requirements as specified by the board.

(d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the appropriate standardized protocol developed under paragraph (b) and, if appropriate, may dispense to a patient a drug described in paragraph (a).

(e) Before dispensing a drug described under paragraph (a) that is prescribed by the pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs and must provide the patient with a fact sheet that includes the indications and contraindications for the use of these drugs, the appropriate method for using these drugs, the need for medical follow up, and any other additional information listed in Minnesota Rules, part 6800.0910, subpart 2, that is required to be provided to a patient during the counseling process.

(f) A pharmacist is prohibited from delegating the prescribing authority provided under this subdivision to any other person. A pharmacist intern registered under section 151.101 may prepare the prescription, but before the prescription is processed or dispensed, a

pharmacist authorized to prescribe under this subdivision must review, approve, and sign the prescription.

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

Sec. 55. Minnesota Statutes 2020, section 151.555, as amended by Laws 2021, chapter 30, article 5, sections 2 to 5, is amended to read:

151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility licensed under chapter 144G;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed

to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription medical supplies needed to administer a ~~prescription~~ drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment; contract and oversight.** (a) By January 1, 2020, the Board of Pharmacy shall establish a ~~drug~~ medication repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5.

(b) The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the ~~prescription drug~~ medication repository program. The contract must:

(1) require the board to transfer to the central repository any money appropriated by the legislature for the purpose of operating the medication repository program and require the central repository to spend any money transferred only for purposes specified in the contract;

(2) require the central repository to report the following performance measures to the board:

(i) the number of individuals served and the types of medications these individuals received;

(ii) the number of clinics, pharmacies, and long-term care facilities with which the central repository partnered;

(iii) the number and cost of medications accepted for inventory, disposed of, and dispensed to individuals in need; and

(iv) locations within the state to which medications are shipped or delivered; and

(3) require the board to annually audit the expenditure by the central repository of any funds appropriated by the legislature and transferred by the board to ensure that this funding is used only for purposes specified in the contract.

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

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

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

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

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~ medication repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's website:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the ~~drug~~ medication repository program is voluntary. A local repository may withdraw from participation in the ~~drug~~ medication repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's website. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the ~~drug~~ medication repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured and is not enrolled in the medical assistance program under chapter 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured e-mail within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's website an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the ~~prescription~~ drug is not a controlled substance.

(c) A medical supply is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the ~~drug~~ medication repository donor form and make it available on the board's website. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored under appropriate temperature and humidity conditions and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated ~~prescription~~ drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an

inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory.

(c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.

A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's website. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the drug repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the drug repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) ~~drug~~ medication repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) ~~drug~~ medication repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~ drugs and medical supplies, must be maintained by a repository for a minimum of two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the ~~drug~~ medication repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care facility to donate a drug to a central or local repository when federal or state law requires the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can credit the payer for the amount of the drug returned.

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

Subd. 15. **Funding.** The central repository may seek grants and other funds from nonprofit charitable organizations, the federal government, and other sources to fund the ongoing operations of the medication repository program.

Sec. 56. Minnesota Statutes 2020, section 152.125, is amended to read:

152.125 INTRACTABLE PAIN.

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

(b) "Drug diversion" means the unlawful transfer of prescription drugs from their licit medical purpose to the illicit marketplace.

(c) "Intractable pain" means a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and in which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. Conditions associated with intractable pain include but are not limited to cancer and the recovery period, sickle cell disease, noncancer pain, rare diseases, orphan diseases, severe injuries, and health conditions requiring the provision of palliative care or hospice care. Reasonable efforts for relieving or curing the cause of the pain may be determined on the basis of, but are not limited to, the following:

(1) when treating a nonterminally ill patient for intractable pain, an evaluation conducted by the attending physician and one or more physicians specializing in pain medicine or the treatment of the area, system, or organ of the body confirmed or perceived as the source of the intractable pain; or

(2) when treating a terminally ill patient, an evaluation conducted by the attending physician who does so in accordance with the standard of care and the level of care, skill, and treatment that would be recognized by a reasonably prudent physician under similar conditions and circumstances.

(d) "Palliative care" has the meaning provided in section 144A.75, subdivision 12.

(e) "Rare disease" means a disease, disorder, or condition that affects fewer than 200,000 individuals in the United States and is chronic, serious, life altering, or life threatening.

Subd. 1a. **Criteria for the evaluation and treatment of intractable pain.** The evaluation and treatment of intractable pain when treating a nonterminally ill patient is governed by the following criteria:

(1) a diagnosis of intractable pain by the treating physician and either by a physician specializing in pain medicine or a physician treating the area, system, or organ of the body that is the source of the pain is sufficient to meet the definition of intractable pain; and

(2) the cause of the diagnosis of intractable pain must not interfere with medically necessary treatment including but not limited to prescribing or administering a controlled substance in Schedules II to V of section 152.02.

Subd. 2. **Prescription and administration of controlled substances for intractable pain.** (a) Notwithstanding any other provision of this chapter, a physician, advanced practice registered nurse, or physician assistant may prescribe or administer a controlled substance in Schedules II to V of section 152.02 to ~~an individual~~ a patient in the course of the physician's, advanced practice registered nurse's, or physician assistant's treatment of the

~~individual~~ patient for a diagnosed condition causing intractable pain. No physician, advanced practice registered nurse, or physician assistant shall be subject to disciplinary action by the Board of Medical Practice or Board of Nursing for appropriately prescribing or administering a controlled substance in Schedules II to V of section 152.02 in the course of treatment of ~~an individual~~ a patient for intractable pain, provided the physician, advanced practice registered nurse, or physician assistant:

(1) keeps accurate records of the purpose, use, prescription, and disposal of controlled substances, writes accurate prescriptions, and prescribes medications in conformance with chapter 147~~.~~ or 148 or in accordance with the current standard of care; and

(2) enters into a patient-provider agreement that meets the criteria in subdivision 5.

(b) No physician, advanced practice registered nurse, or physician assistant, acting in good faith and based on the needs of the patient, shall be subject to any civil or criminal action or investigation, disenrollment, or termination by the commissioner of health or human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations or thresholds specified in state or federal opioid prescribing guidelines or policies, including but not limited to the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention, Minnesota opioid prescribing guidelines, the Minnesota opioid prescribing improvement program, and the Minnesota quality improvement program established under section 256B.0638.

(c) A physician, advanced practice registered nurse, or physician assistant treating intractable pain by prescribing, dispensing, or administering a controlled substance in Schedules II to V of section 152.02 that includes but is not opioid analgesics must not taper a patient's medication dosage solely to meet a predetermined morphine milligram equivalent dosage recommendation or threshold if the patient is stable and compliant with the treatment plan, is experiencing no serious harm from the level of medication currently being prescribed or previously prescribed, and is in compliance with the patient-provider agreement as described in subdivision 5.

(d) A physician's, advanced practice registered nurse's, or physician assistant's decision to taper a patient's medication dosage must be based on factors other than a morphine milligram equivalent recommendation or threshold.

(e) No pharmacist, health plan company, or pharmacy benefit manager shall refuse to fill a prescription for an opiate issued by a licensed practitioner with the authority to prescribe

opiates solely based on the prescription exceeding a predetermined morphine milligram equivalent dosage recommendation or threshold.

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's, advanced practice registered nurse's, or physician assistant's treatment of ~~an individual~~ a patient for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to ~~an individual~~ a patient whom the physician, advanced practice registered nurse, or physician assistant knows to be using the controlled substances for nontherapeutic or drug diversion purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of ~~an individual~~ a patient having intractable pain; or

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief.

Subd. 4. **Notice of risks.** Prior to treating ~~an individual~~ a patient for intractable pain in accordance with subdivision 2, a physician, advanced practice registered nurse, or physician assistant shall discuss with the ~~individual~~ patient or the patient's legal guardian, if applicable, the risks associated with the controlled substances in Schedules II to V of section 152.02 to be prescribed or administered in the course of the physician's, advanced practice registered nurse's, or physician assistant's treatment of ~~an individual~~ a patient, and document the discussion in the ~~individual's~~ patient's record as required in the patient-provider agreement described in subdivision 5.

Subd. 5. **Patient-provider agreement.** (a) Before treating a patient for intractable pain, a physician, advanced practice registered nurse, or physician assistant and the patient or the patient's legal guardian, if applicable, must mutually agree to the treatment and enter into a provider-patient agreement. The agreement must include a description of the prescriber's and the patient's expectations, responsibilities, and rights according to best practices and current standards of care.

(b) The agreement must be signed by the patient or the patient's legal guardian, if applicable, and the physician, advanced practice registered nurse, or physician assistant and

included in the patient's medical records. A copy of the signed agreement must be provided to the patient.

(c) The agreement must be reviewed by the patient and the physician, advanced practice registered nurse, or physician assistant annually. If there is a change in the patient's treatment plan, the agreement must be updated and a revised agreement must be signed by the patient or the patient's legal guardian. A copy of the revised agreement must be included in the patient's medical record and a copy must be provided to the patient.

(d) A patient-provider agreement is not required in an emergency or inpatient hospital setting.

Sec. 57. Minnesota Statutes 2021 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, a physician assistant, or an 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 or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(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.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section

151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage of, and reimbursement for, antiretroviral drugs to prevent the acquisition of human immunodeficiency virus (HIV) and any laboratory testing necessary for therapy that uses these drugs must meet the requirements that would otherwise apply to a health plan under section 62Q.524.

Sec. 58. Minnesota Statutes 2020, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(f) Prior authorization under this subdivision shall comply with ~~section~~ sections 62Q.184 and 62Q.1842.

(g) Any step therapy protocol requirements established by the commissioner must comply with ~~section~~ sections 62Q.1841 and 62Q.1842.

Sec. 59. **STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL PRODUCTS.**

The commissioner of health, within the limits of existing resources, shall analyze the effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of biological products, interchangeable biological products, and biosimilar products. The commissioner of health shall report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy and insurance by December 15, 2024.

ARTICLE 7
HEALTH INSURANCE

Section 1. Minnesota Statutes 2020, section 62A.25, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits 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.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples. ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.~~

(c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on which the mastectomy has been performed~~, including surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages ~~of a mastectomy~~, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or sold on or after that date.

Sec. 2. **[62A.255] COVERAGE OF LYMPHEDEMA TREATMENT.**

Subdivision 1. **Scope of coverage.** This section applies to all health plans that are sold, issued, or renewed to a Minnesota resident.

Subd. 2. **Required coverage.** (a) Each health plan must provide coverage for lymphedema treatment, including coverage for compression treatment items, complex decongestive therapy, and outpatient self-management training and education during lymphedema treatment if prescribed by a licensed health care professional. Lymphedema compression treatment items include: (1) compression garments, stockings, and sleeves; (2) compression devices; and (3) bandaging systems, components, and supplies that are primarily and customarily used in the treatment of lymphedema.

(b) If applicable to the enrollee's health plan, a health carrier may require the prescribing health care professional to be within the enrollee's health plan provider network if the provider network meets network adequacy requirements under section 62K.10.

(c) A health plan must not apply any cost-sharing requirements, benefit limitations, or service limitations for lymphedema treatment and compression treatment items that place a greater financial burden on the enrollee or are more restrictive than cost-sharing requirements or limitations applied by the health plan to other similar services or benefits.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to any health plan issued, sold, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2020, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or sold on or after that date.

Sec. 4. Minnesota Statutes 2020, section 62A.30, is amended by adding a subdivision to read:

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost sharing, including co-pay, deductible, or coinsurance.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or sold on or after that date.

Sec. 5. **[62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.**

Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means a genetic disorder involving the absence or deficiency of tissues and structures derived from the embryonic ectoderm.

Subd. 2. **Coverage.** A health plan must provide coverage for the treatment of ectodermal dysplasias.

Subd. 3. **Dental coverage.** (a) A health plan must provide coverage for dental treatments related to ectodermal dysplasias. Covered dental treatments must include but are not limited to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

(b) If a dental treatment is eligible for coverage under a dental insurance plan or other health plan, the coverage under this subdivision is secondary.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or sold on or after that date.

Sec. 6. **[62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.**

(a) No health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition. Except as provided in paragraph (b), for purposes of this section, "rare disease or condition" means any disease or condition:

(1) that affects less than 200,000 persons in the United States;

(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as such pursuant to United States Code, title 21, section 360bb;

(3) for which a pediatric patient has received two or more clinical consultations with no definitive diagnosis or with conflicting diagnoses, and the pediatric patient has a delay in skill acquisition and development, regression in skill acquisition and development, or rapid progression of symptoms; or

(4) for which a pediatric patient has received at least one clinical consultation from a primary care provider, more than 90 days have elapsed since the initial consultation with no definitive diagnosis, and the pediatric patient has a delay in skill acquisition and development, regression in skill acquisition and development, or rapid progression of symptoms.

(b) A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

(c) Cost-sharing requirements and benefit or services limitations for the diagnosis and treatment of a rare disease or condition must not place a greater financial burden on the enrollee or be more restrictive than those requirements for in-network medical treatment.

(d) This section does not apply to health plan coverage provided through the State Employee Group Insurance Program (SEGIP) under chapter 43A.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 7. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Services for the diagnosis, monitoring, and treatment of rare diseases.** Medical assistance coverage for services related to the diagnosis, monitoring, and treatment of a rare disease or condition must meet the requirements in section 62Q.451.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 8. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Ectodermal dysplasias.** Medical assistance and MinnesotaCare cover treatment for ectodermal dysplasias. Coverage must meet the requirements of sections 62A.25, 62A.28, and 62A.3096.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 9. Minnesota Statutes 2020, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; ~~and~~

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130~~.~~; and

(14) additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 10. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

EFFECTIVE DATE. This section is effective January 1, 2023.

ARTICLE 8
MISCELLANEOUS

Section 1. Minnesota Statutes 2020, section 34A.01, subdivision 4, is amended to read:

Subd. 4. **Food.** "Food" means every ingredient used for, entering into the consumption of, or used or intended for use in the preparation of food, drink, confectionery, or condiment for humans or other animals, whether simple, mixed, or compound; and articles used as components of these ingredients, except that edible cannabinoid products, as defined in section 151.72, subdivision 1, paragraph (c), are not food.

Sec. 2. Minnesota Statutes 2020, section 137.68, is amended to read:

137.68 MINNESOTA RARE DISEASE ADVISORY COUNCIL ~~ON RARE DISEASES~~.

Subdivision 1. **Establishment.** ~~The University of Minnesota is requested to establish~~ There is established an advisory council on rare diseases to provide advice on policies, access, equity, research, diagnosis, treatment, and education related to rare diseases. The advisory council is established in honor of Chloe Barnes and her experiences in the health

care system. For purposes of this section, "rare disease" has the meaning given in United States Code, title 21, section 360bb. The council shall be called the ~~Chloe Barnes Advisory Council on Rare Diseases~~ Minnesota Rare Disease Advisory Council. The Council on Disability shall house the advisory council.

Subd. 2. **Membership.** (a) The advisory council ~~may~~ shall consist of at least 17 public members who reflect statewide representation and are appointed by ~~the Board of Regents or a designee~~ the governor according to paragraph (b) and four members of the legislature appointed according to paragraph (c).

(b) ~~The Board of Regents or a designee is requested to~~ The governor shall appoint at least the following public members according to section 15.059:

(1) three physicians licensed and practicing in the state with experience researching, diagnosing, or treating rare diseases, including one specializing in pediatrics;

(2) one registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases;

(3) at least two hospital administrators, or their designees, from hospitals in the state that provide care to persons diagnosed with a rare disease. One administrator or designee appointed under this clause must represent a hospital in which the scope of service focuses on rare diseases of pediatric patients;

(4) three persons age 18 or older who either have a rare disease or are a caregiver of a person with a rare disease. One person appointed under this clause must reside in rural Minnesota;

(5) a representative of a rare disease patient organization that operates in the state;

(6) a social worker with experience providing services to persons diagnosed with a rare disease;

(7) a pharmacist with experience with drugs used to treat rare diseases;

(8) a dentist licensed and practicing in the state with experience treating rare diseases;

(9) a representative of the biotechnology industry;

(10) a representative of health plan companies;

(11) a medical researcher with experience conducting research on rare diseases; ~~and~~

(12) a genetic counselor with experience providing services to persons diagnosed with a rare disease or caregivers of those persons~~.~~; and

(13) representatives with other areas of expertise as identified by the advisory council.

(c) The advisory council shall include two members of the senate, one appointed by the majority leader and one appointed by the minority leader; and two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader.

(d) The commissioner of health or a designee, a representative of Mayo Medical School, and a representative of the University of Minnesota Medical School shall serve as ex officio, nonvoting members of the advisory council.

(e) ~~Initial appointments to the advisory council shall be made no later than September 1, 2019.~~ Notwithstanding section 15.059, members appointed according to paragraph (b) shall serve for a term of three years, except that the initial members appointed according to paragraph (b) shall have an initial term of two, three, or four years determined by lot by the chairperson. Members appointed according to paragraph (b) shall serve until their successors have been appointed.

(f) Members may be reappointed for additional terms according to the advisory council's operating procedures.

Subd. 3. **Meetings.** ~~The Board of Regents or a designee is requested to convene the first meeting of the advisory council no later than October 1, 2019.~~ The advisory council shall meet at the call of the chairperson or at the request of a majority of advisory council members. Meetings of the advisory council are subject to section 13D.01, and notice of its meetings is governed by section 13D.04.

Subd. 3a. **Chairperson; executive director; staff; executive committee.** (a) The advisory council shall elect a chairperson and other officers as it deems necessary and in accordance with the advisory council's operating procedures.

(b) The advisory council shall be governed by an executive committee elected by the members of the advisory council. One member of the executive committee must be the advisory council chairperson.

(c) The advisory council shall appoint an executive director. The executive director serves as an ex officio nonvoting member of the executive committee. The advisory council may delegate to the executive director any powers and duties under this section that do not require advisory council approval. The executive director serves in the unclassified service and may be removed at any time by a majority vote of the advisory council. The executive

director may employ and direct staff necessary to carry out advisory council mandates, policies, activities, and objectives.

(d) The executive committee may appoint additional subcommittees and work groups as necessary to fulfill the duties of the advisory council.

Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

(1) in conjunction with the state's medical schools, the state's schools of public health, and hospitals in the state that provide care to persons diagnosed with a rare disease, developing resources or recommendations relating to quality of and access to treatment and services in the state for persons with a rare disease, including but not limited to:

(i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases;

(ii) identifying best practices for rare disease care implemented in other states, at the national level, and at the international level that will improve rare disease care in the state and seeking opportunities to partner with similar organizations in other states and countries;

(iii) identifying and addressing problems faced by patients with a rare disease when changing health plans, including recommendations on how to remove obstacles faced by these patients to finding a new health plan and how to improve the ease and speed of finding a new health plan that meets the needs of patients with a rare disease; ~~and~~

(iv) identifying and addressing barriers faced by patients with a rare disease to obtaining care, caused by prior authorization requirements in private and public health plans; and

~~(iv)~~ (v) identifying, recommending, and implementing best practices to ensure health care providers are adequately informed of the most effective strategies for recognizing and treating rare diseases; ~~and~~

(2) advising, consulting, and cooperating with the Department of Health, including the Advisory Committee on Heritable and Congenital Disorders~~.~~; the Department of Human Services, including the Drug Utilization Review Board and the Drug Formulary Committee; and other agencies of state government in developing recommendations, information, and programs for the public and the health care community relating to diagnosis, treatment, and awareness of rare diseases~~.~~;

(3) advising on policy issues and advancing policy initiatives at the state and federal levels; and

(4) receiving funds and issuing grants.

(b) The advisory council shall collect additional topic areas for study and evaluation from the general public. In order for the advisory council to study and evaluate a topic, the topic must be approved for study and evaluation by the advisory council.

Subd. 5. **Conflict of interest.** Advisory council members are subject to the ~~Board of Regents policy on conflicts~~ advisory council's conflict of interest policy as outlined in the advisory council's operating procedures.

Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the advisory council shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over higher education and health care policy on the advisory council's activities under subdivision 4 and other issues on which the advisory council may choose to report.

Sec. 3. Minnesota Statutes 2020, section 151.72, subdivision 1, is amended to read:

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

(b) "Certified hemp" means hemp plants that have been tested and found to meet the requirements of chapter 18K and the rules adopted thereunder.

(c) "Edible cannabinoid product" means any product that is intended to be eaten or consumed as a beverage by humans, contains a cannabinoid in combination with food ingredients, and is not a drug.

~~(b)~~ (d) "Hemp" has the meaning given to "industrial hemp" in section 18K.02, subdivision 3.

(e) "Label" has the meaning given in section 151.01, subdivision 18.

~~(c)~~ (f) "Labeling" means all labels and other written, printed, or graphic matter that are:

(1) affixed to the immediate container in which a product regulated under this section is sold; ~~or~~

(2) provided, in any manner, with the immediate container, including but not limited to outer containers, wrappers, package inserts, brochures, or pamphlets~~.~~; or

(3) provided on that portion of a manufacturer's website that is linked by a scannable barcode or matrix barcode.

(g) "Matrix barcode" means a code that stores data in a two-dimensional array of geometrically shaped dark and light cells capable of being read by the camera on a smartphone or other mobile device.

(h) "Nonintoxicating cannabinoid" means substances extracted from certified hemp plants that do not produce intoxicating effects when consumed by any route of administration.

Sec. 4. Minnesota Statutes 2020, section 151.72, subdivision 2, is amended to read:

Subd. 2. **Scope.** (a) This section applies to the sale of any product that contains ~~nonintoxicating~~ cannabinoids extracted from hemp ~~other than food~~ and that is an edible cannabinoid product or is intended for human or animal consumption by any route of administration.

(b) This section does not apply to any product dispensed by a registered medical cannabis manufacturer pursuant to sections 152.22 to 152.37.

(c) The board must have no authority over food products, as defined in section 34A.01, subdivision 4, that do not contain cannabinoids extracted or derived from hemp.

Sec. 5. Minnesota Statutes 2020, section 151.72, subdivision 3, is amended to read:

Subd. 3. **Sale of cannabinoids derived from hemp.** (a) Notwithstanding any other section of this chapter, a product containing nonintoxicating cannabinoids, including an edible cannabinoid product, may be sold for human or animal consumption only if all of the requirements of this section are met, provided that a product sold for human or animal consumption does not contain more than 0.3 percent of any tetrahydrocannabinol and an edible cannabinoid product does not contain an amount of any tetrahydrocannabinol that exceeds the limits established in subdivision 5a, paragraph (f).

(b) No other substance extracted or otherwise derived from hemp may be sold for human consumption if the substance is intended:

(1) for external or internal use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals; or

(2) to affect the structure or any function of the bodies of humans or other animals.

(c) No product containing any cannabinoid or tetrahydrocannabinol extracted or otherwise derived from hemp may be sold to any individual who is under the age of 21.

(d) Products that meet the requirements of this section are not controlled substances under section 152.02.

Sec. 6. Minnesota Statutes 2020, section 151.72, subdivision 4, is amended to read:

Subd. 4. **Testing requirements.** (a) A manufacturer of a product regulated under this section must submit representative samples of the product to an independent, accredited laboratory in order to certify that the product complies with the standards adopted by the board. Testing must be consistent with generally accepted industry standards for herbal and botanical substances, and, at a minimum, the testing must confirm that the product:

(1) contains the amount or percentage of cannabinoids that is stated on the label of the product;

(2) does not contain more than trace amounts of any mold, residual solvents, pesticides, fertilizers, or heavy metals; and

(3) does not contain ~~a delta-9 tetrahydrocannabinol concentration that exceeds the concentration permitted for industrial hemp as defined in section 18K.02, subdivision 3~~ more than 0.3 percent of any tetrahydrocannabinol.

(b) Upon the request of the board, the manufacturer of the product must provide the board with the results of the testing required in this section.

(c) Testing of the hemp from which the nonintoxicating cannabinoid was derived, or possession of a certificate of analysis for such hemp, does not meet the testing requirements of this section.

Sec. 7. Minnesota Statutes 2021 Supplement, section 151.72, subdivision 5, is amended to read:

Subd. 5. **Labeling requirements.** (a) A product regulated under this section must bear a label that contains, at a minimum:

(1) the name, location, contact phone number, and website of the manufacturer of the product;

(2) the name and address of the independent, accredited laboratory used by the manufacturer to test the product; and

(3) an accurate statement of the amount or percentage of cannabinoids found in each unit of the product meant to be consumed~~; or~~.

~~(4) instead of the information required in clauses (1) to (3), a scannable bar code or QR code that links to the manufacturer's website.~~

(b) The information in paragraph (a) may be provided on an outer package if the immediate container that holds the product is too small to contain all of the information.

(c) The information required in paragraph (a) may be provided through the use of a scannable barcode or matrix barcode that links to a page on the manufacturer's website if that page contains all of the information required by this subdivision.

(d) The label must also include a statement stating that ~~this~~ the product does not claim to diagnose, treat, cure, or prevent any disease and has not been evaluated or approved by the United States Food and Drug Administration (FDA) unless the product has been so approved.

~~(b)~~ (e) The information required ~~to be on the label~~ by this subdivision must be prominently and conspicuously placed ~~and~~ on the label or displayed on the website in terms that can be easily read and understood by the consumer.

~~(c)~~ (f) The ~~label~~ labeling must not contain any claim that the product may be used or is effective for the prevention, treatment, or cure of a disease or that it may be used to alter the structure or function of human or animal bodies, unless the claim has been approved by the FDA.

Sec. 8. Minnesota Statutes 2020, section 151.72, is amended by adding a subdivision to read:

Subd. 5a. **Additional requirements for edible cannabinoid products.** (a) In addition to the testing and labeling requirements under subdivisions 4 and 5, an edible cannabinoid must meet the requirements of this subdivision.

(b) An edible cannabinoid product must not:

(1) bear the likeness or contain cartoon-like characteristics of a real or fictional person, animal, or fruit that appeals to children;

(2) be modeled after a brand of products primarily consumed by or marketed to children;

(3) be made by applying an extracted or concentrated hemp-derived cannabinoid to a commercially available candy or snack food item;

(4) contain an ingredient, other than a hemp-derived cannabinoid, that is not approved by the United States Food and Drug Administration for use in food;

(5) be packaged in a way that resembles the trademarked, characteristic, or product-specialized packaging of any commercially available food product; or

(6) be packaged in a container that includes a statement, artwork, or design that could reasonably mislead any person to believe that the package contains anything other than an edible cannabinoid product.

(c) An edible cannabinoid product must be prepackaged in packaging or a container that is child-resistant, tamper-evident, and opaque or placed in packaging or a container that is child-resistant, tamper-evident, and opaque at the final point of sale to a customer. The requirement that packaging be child-resistant does not apply to an edible cannabinoid product that is intended to be consumed as a beverage and which contains no more than a trace amount of any tetrahydrocannabinol.

(d) If an edible cannabinoid product is intended for more than a single use or contains multiple servings, each serving must be indicated by scoring, wrapping, or other indicators designating the individual serving size.

(e) A label containing at least the following information must be affixed to the packaging or container of all edible cannabinoid products sold to consumers:

(1) the serving size;

(2) the cannabinoid profile per serving and in total;

(3) a list of ingredients, including identification of any major food allergens declared by name; and

(4) the following statement: "Keep this product out of reach of children."

(f) An edible cannabinoid product must not contain more than five milligrams of any tetrahydrocannabinol in a single serving, or more than a total of 50 milligrams of any tetrahydrocannabinol per package.

Sec. 9. Minnesota Statutes 2020, section 151.72, subdivision 6, is amended to read:

Subd. 6. **Enforcement.** (a) A product ~~sold~~ regulated under this section, including an edible cannabinoid product, shall be considered an adulterated drug if:

(1) it consists, in whole or in part, of any filthy, putrid, or decomposed substance;

(2) it has been produced, prepared, packed, or held under unsanitary conditions where it may have been rendered injurious to health, or where it may have been contaminated with filth;

(3) its container is composed, in whole or in part, of any poisonous or deleterious substance that may render the contents injurious to health;

(4) it contains any food additives, color additives, or excipients that have been found by the FDA to be unsafe for human or animal consumption; ~~or~~

(5) it contains an amount or percentage of nonintoxicating cannabinoids that is different than the amount or percentage stated on the label~~.~~;

(6) it contains more than 0.3 percent of any tetrahydrocannabinol or, if the product is an edible cannabinoid product, an amount of tetrahydrocannabinol that exceeds the limits established in subdivision 5a, paragraph (f); or

(7) it contains more than trace amounts of mold, residual solvents, pesticides, fertilizers, or heavy metals.

(b) A product ~~sold~~ regulated under this section shall be considered a misbranded drug if the product's labeling is false or misleading in any manner or in violation of the requirements of this section.

(c) The board's authority to issue cease and desist orders under section 151.06; to embargo adulterated and misbranded drugs under section 151.38; and to seek injunctive relief under section 214.11, extends to any violation of this section.

Sec. 10. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance, the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II:

(1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or

(2) with respect to a particular person, if the person represents or intends that the substance have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.

(b) "Analog" does not include:

(1) a controlled substance;

(2) any substance for which there is an approved new drug application under the Federal Food, Drug, and Cosmetic Act; ~~or~~

(3) with respect to a particular person, any substance, if an exemption is in effect for investigational use, for that person, as provided by United States Code, title 21, section 355, and the person is registered as a controlled substance researcher as required under section 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the exemption and registration; or

(4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant.

EFFECTIVE DATE. This section is effective August 1, 2022, and applies to crimes committed on or after that date.

Sec. 11. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

(1) acetylmethadol;

(2) allylprodine;

(3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);

(4) alphameprodine;

(5) alphamethadol;

(6) alpha-methylfentanyl benzethidine;

(7) betacetylmethadol;

(8) betameprodine;

(9) betamethadol;

(10) betaprodine;

(11) clonitazene;

(12) dextromoramide;

(13) diampromide;

(14) diethyliambutene;

(15) difenoxin;

(16) dimenoxadol;

(17) dimepheptanol;

(18) dimethyliambutene;

(19) dioxaphetyl butyrate;

(20) dipipanone;

(21) ethylmethylthiambutene;

(22) etonitazene;

(23) etoxeridine;

(24) furethidine;

(25) hydroxypethidine;

(26) ketobemidone;

(27) levomoramide;

(28) levophenacylmorphan;

(29) 3-methylfentanyl;

(30) acetyl-alpha-methylfentanyl;

(31) alpha-methylthiofentanyl;

(32) benzylfentanyl beta-hydroxyfentanyl;

(33) beta-hydroxy-3-methylfentanyl;

(34) 3-methylthiofentanyl;

(35) thenylfentanyl;

(36) thiofentanyl;

(37) para-fluorofentanyl;

(38) morpheridine;

(39) 1-methyl-4-phenyl-4-propionoxypiperidine;

(40) noracymethadol;

(41) norlevorphanol;

(42) normethadone;

(43) norpipanone;

(44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

(45) phenadoxone;

(46) phenampromide;

(47) phenomorphan;

(48) phenoperidine;

(49) piritramide;

(50) proheptazine;

(51) properidine;

(52) propiram;

(53) racemoramide;

(54) tilidine;

(55) trimeperidine;

(56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

(57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-methylbenzamide(U47700);

(58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);

(59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropryl fentanyl);

(61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);

(62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);

(63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl fentanyl);

(64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);

(65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

(66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (para-chloroisobutyryl fentanyl);

(67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl fentanyl);

(68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-methoxybutyryl fentanyl);

(69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);

(70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl fentanyl or para-fluoroisobutyryl fentanyl);

(71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or acryloylfentanyl);

(72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl fentanyl);

(73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl or 2-fluorofentanyl);

(74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide (tetrahydrofuranyl fentanyl); and

(75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers, meaning any substance not otherwise listed under another federal Administration Controlled Substance Code Number or not otherwise listed in this section, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related to fentanyl by one or more of the following modifications:

(i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iv) replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; or

(v) replacement of the N-propionyl group by another acyl group.

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine; and

(23) thebacon.

(d) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional, or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) methylenedioxy amphetamine;

(2) methylenedioxymethamphetamine;

(3) methylenedioxy-N-ethylamphetamine (MDEA);

(4) n-hydroxy-methylenedioxyamphetamine;

(5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

(6) 2,5-dimethoxyamphetamine (2,5-DMA);

(7) 4-methoxyamphetamine;

(8) 5-methoxy-3, 4-methylenedioxyamphetamine;

(9) alpha-ethyltryptamine;

(10) bufotenine;

(11) diethyltryptamine;

(12) dimethyltryptamine;

(13) 3,4,5-trimethoxyamphetamine;

(14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

(15) ibogaine;

(16) lysergic acid diethylamide (LSD);

(17) mescaline;

(18) parahexyl;

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) psilocybin;

(22) psilocyn;

(23) tenocyclidine (TPCP or TCP);

(24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

(25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

(26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

(27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

(28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

(29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

(30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

(31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

(32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);

(33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

(34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

(35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

(36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

(37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

(38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);

(39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

(40) alpha-methyltryptamine (AMT);

(41) N,N-diisopropyltryptamine (DiPT);

(42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

(43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

(44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

(45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

(46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

(47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

(48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

(49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

(50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

(51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

(52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);

(53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

(54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

(55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

(56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);

(57) methoxetamine (MXE);

(58) 5-iodo-2-aminoindane (5-IAI);

(59) 5,6-methylenedioxy-2-aminoindane (MDAI);

(60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);

(61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);

(62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);

(63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

(64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);

(65) N,N-Dipropyltryptamine (DPT);

(66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);

(67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);

(68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);

(69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

(70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine, ethketamine, NENK);

(71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

(72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

(73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

(e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,

its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) mecloqualone;

(2) methaqualone;

(3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

(4) flunitrazepam;

(5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine, methoxyketamine);

(6) tianeptine;

(7) clonazolam;

(8) etizolam;

(9) flubromazolam; and

(10) flubromazepam.

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) aminorex;

(2) cathinone;

(3) fenethylline;

(4) methcathinone;

(5) methylaminorex;

(6) N,N-dimethylamphetamine;

(7) N-benzylpiperazine (BZP);

(8) methylmethcathinone (mephedrone);

(9) 3,4-methylenedioxy-N-methylcathinone (methylone);

(10) methoxymethcathinone (methedrone);

(11) methylenedioxypyrovalerone (MDPV);

(12) 3-fluoro-N-methylcathinone (3-FMC);

(13) methylethcathinone (MEC);

(14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

(15) dimethylmethcathinone (DMMC);

(16) fluoroamphetamine;

(17) fluoromethamphetamine;

(18) α-methylaminobutyrophenone (MABP or buphedrone);

(19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

(20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

(21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or naphyrone);

(22) (alpha-pyrrolidinopentiophenone (alpha-PVP);

(23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

(24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);

(25) 4-methyl-N-ethylcathinone (4-MEC);

(26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);

(27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);

(28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

(29) 4-fluoro-N-methylcathinone (4-FMC);

(30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

(31) alpha-pyrrolidinobutiophenone (α-PBP);

(32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);

(33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);

(34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);

(35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);

(36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);

(37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);

(38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);

(39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone); and

(40) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) ~~Marijuana,~~ Synthetic tetrahydrocannabinols~~,~~ and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

~~(1) marijuana;~~

~~(2)~~ (1) synthetic tetrahydrocannabinols ~~naturally contained in a plant of the genus Cannabis,~~ that are the synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous

extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol; and

~~(3)~~ (2) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

(C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

(D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

(F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

(G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

(I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Napthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

(A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

(B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any

extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylemethylindenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

(A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

(B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

(D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl] -phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de] -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole- 3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]- 1H-indazole-3-carboxamide (AB-FUBINACA);

(L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide(AB-CHMINACA);

(M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate (5-fluoro-AMB);

(N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);

(O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone) (FUBIMINA);

(P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

(Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide (5-fluoro-ABICA);

(R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide;

(S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indazole-3-carboxamide;

(T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;

(U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1 H-indazole-3-carboxamide (MAB-CHMINACA);

(V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA);

(W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

(X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-3-carboxamide. (APP-CHMINACA);

(Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

(Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).

(ix) Additional substances specifically named:

(A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);

(B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide (4-CN-Cumyl-Butinaca);

(C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);

(D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1 H-indazole-3-carboxamide (5F-ABPINACA);

(E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate (MDMB CHMICA);

(F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate (5F-ADB; 5F-MDMB-PINACA); and

(G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl) 1H-indazole-3-carboxamide (ADB-FUBINACA).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly intended for human consumption.

EFFECTIVE DATE. This section is effective August 1, 2022, and applies to crimes committed on or after that date.

Sec. 12. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(i) Excluding:

(A) apomorphine;

(B) thebaine-derived butorphanol;

(C) dextrophan;

(D) nalbuphine;

(E) nalmefene;

(F) naloxegol;

(G) naloxone;

(H) naltrexone; and

(I) their respective salts;

(ii) but including the following:

(A) opium, in all forms and extracts;

(B) codeine;

(C) dihydroetorphine;

(D) ethylmorphine;

(E) etorphine hydrochloride;

(F) hydrocodone;

(G) hydromorphone;

(H) metopon;

(I) morphine;

(J) oxycodone;

(K) oxymorphone;

(L) thebaine;

(M) oripavine;

(2) any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), except that these substances shall not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine;

(5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy).

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) alfentanil;

(2) alphaprodine;

(3) anileridine;

(4) bezitramide;

(5) bulk dextropropoxyphene (nondosage forms);

(6) carfentanil;

(7) dihydrocodeine;

(8) dihydromorphinone;

(9) diphenoxylate;

(10) fentanyl;

(11) isomethadone;

(12) levo-alpha-acetylmethadol (LAAM);

(13) levomethorphan;

(14) levorphanol;

(15) metazocine;

(16) methadone;

(17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

(18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid;

(19) pethidine;

(20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

(21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

(22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(23) phenazocine;

(24) piminodine;

(25) racemethorphan;

(26) racemorphan;

(27) remifentanil;

(28) sufentanil;

(29) tapentadol;

(30) 4-Anilino-N-phenethylpiperidine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) methamphetamine, its salts, isomers, and salts of its isomers;

(3) phenmetrazine and its salts;

(4) methylphenidate;

(5) lisdexamfetamine.

(e) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) amobarbital;

(2) glutethimide;

(3) secobarbital;

(4) pentobarbital;

(5) phencyclidine;

(6) phencyclidine immediate precursors:

(i) 1-phenylcyclohexylamine;

(ii) 1-piperidinocyclohexanecarbonitrile;

(7) phenylacetone.

(f) Cannabis and cannabinoids:

(1) nabilone;

(2) unless specifically excepted or unless listed in another schedule, any natural material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(i) marijuana; and

(ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant, except that a product containing tetrahydrocannabinols is not included if it meets the requirements of section 151.72; and

~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

EFFECTIVE DATE. This section is effective August 1, 2022, and applies to crimes committed on or after that date.

Sec. 13. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 14. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to read:

Subd. 6. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 15. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the physician knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; ~~or~~

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief; or

(5) the administration of medical cannabis under sections 152.22 to 152.37.

Sec. 16. Minnesota Statutes 2020, section 152.32, subdivision 1, is amended to read:

Subdivision 1. ~~**Presumption**~~ **Presumptions.** (a) There is a presumption that a patient enrolled in the registry program under sections 152.22 to 152.37 is engaged in the authorized use of medical cannabis.

(b) The presumption in paragraph (a) may be rebutted by evidence that conduct related to use of medical cannabis was not for the purpose of treating or alleviating the patient's qualifying medical condition or symptoms associated with the patient's qualifying medical condition.

(c) Sections 152.22 to 152.37 do not create any positive conflict with federal drug laws or regulations and are consistent with United States Code, title 21, section 903.

Sec. 17. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

(k) Subject to section 152.23, the listing of tetrahydrocannabinols as a Schedule I controlled substance under this chapter does not apply to protected activities specified in this subdivision.

Sec. 18. Minnesota Statutes 2021 Supplement, section 363A.50, is amended to read:

363A.50 NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given unless the context clearly requires otherwise.

(b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

(c) "Auxiliary aids and services" include, but are not limited to:

(1) qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments and to non-English-speaking individuals;

(2) qualified readers, taped texts, texts in accessible electronic format, or other effective methods of making visually delivered materials available to individuals with visual impairments;

(3) the provision of information in a format that is accessible for individuals with cognitive, neurological, developmental, intellectual, or physical disabilities;

(4) the provision of supported decision-making services; and

(5) the acquisition or modification of equipment or devices.

(d) "Covered entity" means:

(1) any licensed provider of health care services, including licensed health care practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric residential treatment facilities, institutions for individuals with intellectual or developmental disabilities, and prison health centers; or

(2) any entity responsible for matching anatomical gift donors to potential recipients.

(e) "Disability" has the meaning given in section 363A.03, subdivision 12.

(f) "Organ transplant" means the transplantation or infusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition.

(g) "Qualified individual" means an individual who, with or without available support networks, the provision of auxiliary aids and services, or reasonable modifications to policies

or practices, meets the essential eligibility requirements for the receipt of an anatomical gift.

(h) "Reasonable modifications" include, but are not limited to:

(1) communication with individuals responsible for supporting an individual with postsurgical and post-transplantation care, including medication; and

(2) consideration of support networks available to the individual, including family, friends, and home and community-based services, including home and community-based services funded through Medicaid, Medicare, another health plan in which the individual is enrolled, or any program or source of funding available to the individual, in determining whether the individual is able to comply with post-transplant medical requirements.

(i) "Supported decision making" has the meaning given in section 524.5-102, subdivision 16a.

Subd. 2. **Prohibition of discrimination.** (a) A covered entity may not, on the basis of a qualified individual's race, ethnicity, mental disability, or physical disability:

(1) deem an individual ineligible to receive an anatomical gift or organ transplant;

(2) deny medical or related organ transplantation services, including evaluation, surgery, counseling, and postoperative treatment and care;

(3) refuse to refer the individual to a transplant center or other related specialist for the purpose of evaluation or receipt of an anatomical gift or organ transplant;

(4) refuse to place an individual on an organ transplant waiting list or place the individual at a lower-priority position on the list than the position at which the individual would have been placed if not for the individual's race, ethnicity, or disability; or

(5) decline insurance coverage for any procedure associated with the receipt of the anatomical gift or organ transplant, including post-transplantation and postinfusion care.

(b) Notwithstanding paragraph (a), a covered entity may take an individual's disability into account when making treatment or coverage recommendations or decisions, solely to the extent that the physical or mental disability has been found by a physician, following an individualized evaluation of the potential recipient to be medically significant to the provision of the anatomical gift or organ transplant. The provisions of this section may not be deemed to require referrals or recommendations for, or the performance of, organ transplants that are not medically appropriate given the individual's overall health condition.

(c) If an individual has the necessary support system to assist the individual in complying with post-transplant medical requirements, an individual's inability to independently comply with those requirements may not be deemed to be medically significant for the purposes of paragraph (b).

(d) A covered entity must make reasonable modifications to policies, practices, or procedures, when such modifications are necessary to make services such as transplantation-related counseling, information, coverage, or treatment available to qualified individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such services.

(e) A covered entity must take such steps as may be necessary to ensure that no qualified individual with a disability is denied services such as transplantation-related counseling, information, coverage, or treatment because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the services being offered or result in an undue burden. A covered entity is not required to provide supported decision-making services.

(f) A covered entity must otherwise comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, the Americans with Disabilities Act Amendments Act of 2008, and the Minnesota Human Rights Act.

(g) The provisions of this section apply to each part of the organ transplant process.

Subd. 3. **Remedies.** In addition to all other remedies available under this chapter, any individual who has been subjected to discrimination in violation of this section may initiate a civil action in a court of competent jurisdiction to enjoin violations of this section.

Sec. 19. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL USE OF CANNABIS.**

By September 1, 2022, the commissioner of health shall apply to the Drug Enforcement Administration's Office of Diversion Control for an exception under Code of Federal Regulations, title 21, section 1307.03, and request formal written acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota Statutes, sections 152.22 to 152.37. The application must include the list of presumptions in Minnesota Statutes, section 152.32, subdivision 1.

Sec. 20. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber as Minnesota Statutes, section 256.4835, the Minnesota Rare Disease Advisory Council that is currently coded as Minnesota Statutes, section 137.68. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

ARTICLE 9
FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

	APPROPRIATIONS Available for the Year Ending June 30	
	2022	**2023**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (585,901,000)**	**$ 182,791,000**
Appropriations by Fund		
General Fund	(406,629,000)	185,395,000
Health Care Access Fund	(86,146,000)	(11,799,000)
Federal TANF	(93,126,000)	9,195,000
Subd. 2. **Forecasted Programs**		
(a) **MFIP/DWP**		
Appropriations by Fund		
General Fund	72,106,000	(14,397,000)
Federal TANF	(93,126,000)	9,195,000

(b) **MFIP Child Care Assistance**		(103,347,000)	(73,738,000)
(c) **General Assistance**		(4,175,000)	(1,488,000)
(d) **Minnesota Supplemental Aid**		318,000	1,613,000
(e) **Housing Support**		(1,994,000)	9,257,000
(f) **Northstar Care for Children**		(9,613,000)	(4,865,000)
(g) **MinnesotaCare**		(86,146,000)	(11,799,000)

These appropriations are from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund	
General Fund	(348,364,000)	292,880,000
Health Care Access Fund	-0-	-0-

(i) **Alternative Care Program**	-0-	-0-
(j) **Behavioral Health Fund**	(11,560,000)	(23,867,000)
Subd. 3. **Technical Activities**	-0-	-0-

These appropriations are from the federal TANF fund.

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

ARTICLE 10
APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2021, First Special Session chapter 7, article 16. Supplemental appropriations and reductions to appropriations for the

fiscal year ending June 30, 2022, are effective the day following final enactment unless a different effective date is explicit.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2022	2023

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	$	**36,333,000**	$ **308,379,000**

Appropriations by Fund

	2022	2023
General	34,397,000	401,851,000
Health Care Access	1,936,000	(94,030,000)
Federal TANF	-0-	7,000
Opiate Epidemic Response	-0-	551,000

Subd. 2. **Central Office; Operations**

Appropriations by Fund

General	397,000	96,197,000
Health Care Access	-0-	10,029,000

(a) **Background Studies.** (1) $1,779,000 in fiscal year 2023 is to provide a credit to providers who paid for emergency background studies in NETStudy 2.0. This is a onetime appropriation.

(2) $1,851,000 in fiscal year 2023 is to fund the costs of reprocessing emergency studies conducted under interagency agreements. This is a onetime appropriation.

(b) **Supporting Drug Pricing Litigation Costs.** $228,000 in fiscal year 2022 is for costs to comply with litigation requirements related

to pharmaceutical drug price litigation. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is increased $11,788,000 in fiscal year 2024 and $9,301,000 in fiscal year 2025. The health care access fund base is increased $636,000 in fiscal year 2024 and $2,015,000 in fiscal year 2025.

Subd. 3. **Central Office; Children and Families**		-0-	21,888,000

(a) **Foster Care Federal Cash Assistance Benefits Plan.** $373,000 in fiscal year 2023 is for the commissioner to develop the foster care federal cash assistance benefits plan. The base for this appropriation is $342,000 in fiscal year 2024 and $127,000 in fiscal year 2025.

(b) **Commissioner of Education.** $53,000 in fiscal year 2023 is for transfer to the commissioner of education for staffing for the family and community resources hubs. The base for this appropriation is $61,000 in fiscal year 2024 and $61,000 in fiscal year 2025.

(c) **Commissioner of Health.** $53,000 in fiscal year 2023 is for transfer to the commissioner of health for staffing for the family and community resources hubs. The base for this appropriation is $61,000 in fiscal year 2024 and $61,000 in fiscal year 2025.

(d) **Children's Cabinet.** The base shall include $61,000 in fiscal year 2024 and $61,000 in fiscal year 2025 for staffing at the Children's Cabinet at the Department of Management and Budget for the family and community resources hubs.

(e) **Base Level Adjustment.** The general fund base is increased $7,782,000 in fiscal year 2024 and $7,537,000 in fiscal year 2025.

Subd. 4. **Central Office; Health Care**

Appropriations by Fund		
General	-0-	4,500,000
Health Care Access	-0-	811,000

(a) **Interactive Voice Response and Improving Access for Applications and Forms.** $1,350,000 in fiscal year 2023 is for the improvement of accessibility to Minnesota health care programs applications, forms, and other consumer support resources and services to enrollees with limited English proficiency. This is a onetime appropriation.

(b) **Community-Driven Improvements.** $680,000 in fiscal year 2023 is for Minnesota health care program enrollee engagement activities.

(c) **Responding to COVID-19 in Minnesota Health Care Programs.** $1,000,000 in fiscal year 2023 is for contract assistance relating to the resumption of eligibility and redetermination processes in Minnesota health care programs after the expiration of the federal public health emergency. Contracts entered into under this section are for emergency acquisition and are not subject to solicitation requirements under Minnesota Statutes, section 16C.10, subdivision 2. This is a onetime appropriation and is available until June 30, 2025.

(d) **Initial PACE Implementation Funding.** $270,000 in fiscal year 2023 is from the

general fund to complete the initial actuarial and administrative work necessary to recommend a financing mechanism for the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e).

(e) **Base Level Adjustment.** The general fund base is increased $3,607,000 in fiscal year 2024 and $3,147,000 in fiscal year 2025. The health care access fund base is increased $2,547,000 in fiscal year 2024 and $5,715,000 in fiscal year 2025.

Subd. 5. **Central Office; Continuing Care** -0- 177,000

(a) **Lifesharing Services.** $57,000 in fiscal year 2023 is for engaging stakeholders and developing recommendations regarding establishing a lifesharing service under the state's medical assistance disability waivers and elderly waiver. The base for this appropriation is $43,000 in fiscal year 2024.

(b) **Initial PACE Implementation Funding.** $120,000 in fiscal year 2023 is to complete the initial actuarial and administrative work necessary to recommend a financing mechanism for the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e).

(c) **Base Level Adjustment.** The general fund base is increased $43,000 in fiscal year 2024.

Subd. 6. **Central Office; Community Supports**

Appropriations by Fund		
General	-0-	8,531,000
Opioid Epidemic Response	-0-	551,000

(a) **SEIU Health Care Arbitration Award.** $5,444 in fiscal year 2023 is for arbitration awards resulting from a SEIU grievance. This is a onetime appropriation.

(b) **Lifesharing Services.** $57,000 in fiscal year 2023 is from the general fund for engaging stakeholders and developing recommendations regarding establishing a lifesharing service under the state's medical assistance disability waivers and elderly waiver. The general fund base for this appropriation is $43,000 in fiscal year 2024.

(c) **Intermediate Care Facilities for Persons with Developmental Disabilities; Rate Study.** $250,000 in fiscal year 2023 is from the general fund for a study of medical assistance rates for intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, sections 256B.5011 to 256B.5015. This is a onetime appropriation.

(d) **Base Level Adjustment.** The general fund base is increased $9,803,000 in fiscal year 2024 and $8,105,000 in fiscal year 2025.

Subd. 7. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	-0-	4,000
Federal TANF	-0-	7,000

Subd. 8. **Forecasted Programs; MFIP Child Care Assistance** -0- 1,000

Subd. 9. **Forecasted Programs; Minnesota Supplemental Aid** -0- 1,000

Subd. 10. **Forecasted Programs; Housing Supports** -0- 2,181,000

Subd. 11. **Forecasted Programs; MinnesotaCare**

Appropriations by Fund

General -0- (17,943,000)

Health Care Access -0- 29,066,000

This appropriation is from the health care access fund.

Subd. 12. **Forecasted Programs; Medical Assistance**

Appropriations by Fund

General -0- (56,603,000)

Health Care Access -0- (134,000,000)

Subd. 13. **Forecasted Programs; Alternative Care** -0- 530,000

Subd. 14. **Grant Programs; BSF Child Care Grants** -0- 6,000

Base Level Adjustment. The general fund base is increased $29,000 in fiscal year 2024 and $248,000 in fiscal year 2025.

Subd. 15. **Grant Programs; Child Care Development Grants** -0- -0-

Subd. 16. **Grant Programs; Children's Services Grants** -0- 9,032,000

(a) **American Indian Child Welfare Initiative; Mille Lacs Band of Ojibwe Planning.** $1,263,000 in fiscal year 2023 is to support activities necessary for the Mille Lacs Band of Ojibwe to join the American Indian child welfare initiative.

(b) **Expand Parent Support Outreach Program.** The base shall include $7,000,000 in fiscal year 2024 and $7,000,000 in fiscal year 2025 to expand the parent support outreach program to community-based agencies, public health agencies, and schools to prevent reporting of and entry into the child welfare system.

(c) **Thriving Families Safer Children.** The base shall include $30,000 in fiscal year 2024 to plan for an education attendance support diversionary program to prevent entry into the child welfare system. The commissioner shall report back to the legislative committees that oversee child welfare by January 1, 2025, on the plan for this program. This is a onetime appropriation.

(d) **Family Group Decision Making.** The base shall include $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 to expand the use of family group decision making to provide opportunity for family voices concerning critical decisions in child safety and prevent entry into the child welfare system.

(e) **Child Welfare Promising Practices.** The base shall include $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 to develop promising practices for prevention of out-of-home placement of children and youth.

(f) **Family Assessment Response.** The base shall include $23,550,000 in fiscal year 2024 and $23,550,000 in fiscal year 2025 to support counties and Tribes that are members of the American Indian child welfare initiative in providing case management services and support for families being served under family assessment response, and prevent entry into the child welfare system.

(g) **Extend Support for Youth Leaving Foster Care.** $600,000 in fiscal year 2023 is to extend financial supports for young adults aging out of foster care to age 22.

(h) **Grants to Counties for Child Protection Staff.** $1,000,000 in fiscal year 2023 is to provide grants to counties and American Indian child welfare initiative Tribes to be used to reduce extended foster care caseload sizes to ten cases per worker.

(i) **Statewide Pool of Qualified Individuals.** $1,177,400 in fiscal year 2023 is for grants to one or more grantees to establish and manage a pool of state-funded qualified individuals to assess potential out-of-home placement of a child in a qualified residential treatment program. Up to $200,000 of the grants each fiscal year is available for grantee contracts to manage the state-funded pool of qualified individuals. This amount shall also pay for qualified individual training, certification, and background studies. Remaining grant money shall be used until expended to provide qualified individual services to counties and Tribes that have joined the American Indian child welfare initiative pursuant to Minnesota Statutes, section 256.01, subdivision 14b, to provide qualified residential treatment program assessments at no cost to the county or Tribal agency.

(j) **Quality Parenting Initiative Grant.** $100,000 in fiscal year 2023 is for a grant to the Quality Parenting Initiative Minnesota, to implement Quality Parenting Initiative principles and practices and support children and families experiencing foster care placements. The grantee shall use grant funds to provide training and technical assistance to county and Tribal agencies, community-based

agencies, and other stakeholders, on conducting initial foster care phone calls under Minnesota Statutes, section 260C.219, subdivision 6; supporting practices that create birth family to foster family partnerships; and informing child welfare practices by supporting youth leadership and the participation of individuals with experience in the foster care system. Upon request, the commissioner shall make information regarding the use of this grant funding available to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. This is a onetime appropriation.

(k) **Costs of Foster Care or Care, Examination, or Treatment.** $5,000,000 in fiscal year 2023 is for grants to counties and Tribes, to reimburse counties and Tribes for the costs of foster care or care, examination, or treatment that would previously have been paid by the parents or custodians of a child in foster care using parental income and resources, child support payments, or income and resources attributable to a child under Minnesota Statutes, sections 242.19, 256N.26, 260B.331, and 260C.331. Counties and Tribes must apply for grant funds in a form prescribed by the commissioner, and must provide the information and data necessary to calculate grant fund allocations accurately and equitably, as required by the commissioner.

(l) **Grants to Counties; Foster Care Federal Cash Assistance Benefits Plan.** $50,000 in fiscal year 2023 is for the commissioner to

provide grants to counties, to assist counties with gathering and reporting the county data required for the commissioner to develop the foster care federal cash assistance benefits plan.

(m) **Base Level Adjustment.** The general fund base is increased $52,440,000 in fiscal year 2024 and $49,769,000 in fiscal year 2025.

Subd. 17. **Grant Programs; Children and Community Service Grants**	-0-	-0-

Base Level Adjustment. The opiate epidemic response base is increased $100,000 in fiscal year 2025.

Subd. 18. **Grant Programs; Children and Economic Support Grants**	14,000,000	144,386,000

(a) **Family and Community Resource Hubs.** $2,550,000 in fiscal year 2023 is to implement a sustainable family and community resource hub model through the community action agencies under Minnesota Statutes, section 256E.31, and federally recognized Tribes. The community resource hubs must offer navigation to several supports and services, including but not limited to basic needs and economic assistance, disability services, healthy development and screening, developmental and behavioral concerns, family well-being and mental health, early learning and child care, dental care, legal services, and culturally specific services for American Indian families.

(b) **Tribal Food Sovereignty Infrastructure Grants.** $4,000,000 in fiscal year 2023 is for capital and infrastructure development to support food system changes and provide

equitable access to existing and new methods of food support for American Indian communities, including federally recognized Tribes and American Indian nonprofit organizations. This is a onetime appropriation and is available until June 30, 2025.

(c) **Tribal Food Security.** $2,836,000 in fiscal year 2023 is to promote food security for American Indian communities, including federally recognized Tribes and American Indian nonprofit organizations. This includes hiring staff, providing culturally relevant training for building food access, purchasing technical assistance materials and supplies, and planning for sustainable food systems.

(d) **Capital for Emergency Food Distribution Facilities.** $14,931,000 in fiscal year 2023 is for improving and expanding the infrastructure of food shelf facilities across the state, including adding freezer or cooler space and dry storage space, improving the safety and sanitation of existing food shelves, and addressing deferred maintenance or other facility needs of existing food shelves. Grant money shall be made available to nonprofit organizations, federally recognized Tribes, and local units of government. This is a onetime appropriation and is available until June 30, 2025.

(e) **Food Support Grants.** $5,000,000 in fiscal year 2023 is to provide additional resources to a diverse food support network that includes food shelves, food banks, and meal and food outreach programs. Grant money shall be made available to nonprofit

organizations, federally recognized Tribes, and local units of government.

(f) **Transitional Housing.** $2,500,000 in fiscal year 2023 is for transitional housing programs under Minnesota Statutes, section 256E.33.

(g) **Shelter-Linked Youth Mental Health Grants.** $1,650,000 in fiscal year 2023 is for shelter-linked youth mental health grants under Minnesota Statutes, section 256K.46.

(h) **Emergency Services Grants.** $35,000,000 in fiscal year 2023 is for emergency services under Minnesota Statutes, section 256E.36. The base for this appropriation is $25,000,000 in fiscal year 2024 and $25,000,000 in fiscal year 2025. Grant allocation balances in the first year do not cancel but are available in the second year.

(i) **Homeless Youth Act.** $10,000,000 in fiscal year 2023 is for homeless youth act grants under Minnesota Statutes, section 256K.45, subdivision 1. Grant allocation balances in the first year do not cancel but are available in the second year.

(j) **Pregnant and Parenting Homeless Youth Study.** $300,000 in fiscal year 2023 is to fund a study of the prevalence of pregnancy and parenting among homeless youths and youths who are at risk of homelessness. This is a onetime appropriation and is available until June 30, 2024.

(k) **Safe Harbor Grants.** $5,500,000 in fiscal year 2023 is for safe harbor grants to fund street outreach, emergency shelter, and transitional and long-term housing beds for

sexually exploited youth and youth at risk of exploitation.

(l) **Emergency Shelter Facilities.** $75,000,000 in fiscal year 2023 is for grants to eligible applicants for the acquisition of property, site preparation, including demolition, predesign, design, construction, renovation, furnishing, and equipping of emergency shelter facilities in accordance with emergency shelter facilities project criteria in this act. This is a onetime appropriation and is available until June 30, 2025.

(m) **Heading Home Ramsey Continuum of Care.** (1) $8,000,000 in fiscal year 2022 is for a grant to fund and support Heading Home Ramsey Continuum of Care. This is a onetime appropriation. The grant shall be used for:

(i) maintaining funding for a 100-bed family shelter that had been funded by CARES Act money;

(ii) maintaining funding for an existing 100-bed single room occupancy shelter and developing a replacement single-room occupancy shelter for housing up to 100 single adults; and

(iii) maintaining current day shelter programming that had been funded with CARES Act money and developing a replacement for current day shelter facilities.

(2) Ramsey County may use up to ten percent of this appropriation for administrative expenses. The commissioner shall make available the grant funds under this section by

May 1, 2022. This appropriation is available until June 30, 2025.

(n) **Hennepin County Funding for Serving Homeless Persons.** (1) $6,000,000 in fiscal year 2022 is for a grant to fund and support Hennepin County shelters and services for persons experiencing homelessness. This is a onetime appropriation. Of this appropriation:

(i) up to $4,000,000 in matching grant funding is to design, construct, equip, and furnish Simpson Housing Services shelter facility in the city of Minneapolis; and

(ii) up to $2,000,000 is to maintain current shelter and homeless response programming that had been funded with federal funding from the CARES Act of the American Rescue Plan Act, including:

(A) shelter operations and services to maintain services at Avivo Village, including a shelter comprised of 100 private dwellings and the American Indian Community Development Corporation Homeward Bound 50-bed shelter;

(B) shelter operations and services to maintain shelter services 24 hours per day, seven days per week;

(C) housing-focused case management; and

(D) shelter diversion services.

(2) Hennepin County may contract with eligible nonprofit organizations and local and Tribal governmental units to provide services under the grant program. This appropriation is available until June 30, 2025.

(o) **Chosen Family Hosting to Prevent Youth Homelessness Pilot Program.** $1,000,000 in fiscal year 2023 is for the chosen family hosting to prevent youth homelessness pilot program to provide funds to providers serving homeless youth. Of this amount, $218,000 is for a contract with a technical assistance provider to: (1) provide technical assistance to funding recipients; (2) facilitate a monthly learning cohort for funding recipients; (3) evaluate the efficacy and cost-effectiveness of the pilot program; and (4) submit annual updates and a final report to the commissioner. This is a onetime appropriation and is available until June 30, 2027.

(p) **Minnesota Association for Volunteer Administration.** $1,000,000 in fiscal year 2023 is for a grant to the Minnesota Association for Volunteer Administration to administer needs-based volunteerism subgrants targeting underresourced nonprofit organizations in greater Minnesota to support selected organizations' ongoing efforts to address and minimize disparities in access to human services through increased volunteerism. Successful subgrant applicants must demonstrate that the populations to be served by the subgrantee are considered underserved or suffer from or are at risk of homelessness, hunger, poverty, lack of access to health care, or deficits in education. The Minnesota Association for Volunteer Administration must give priority to organizations that are serving the needs of vulnerable populations. By December 15,

2023, the Minnesota Association for Volunteer Administration must report data on outcomes from the subgrants and recommendations for improving and sustaining volunteer efforts statewide to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services. This is a onetime appropriation and is available until June 30, 2024.

(q) **Base Level Adjustment.** The general fund base is increased $61,559,000 in fiscal year 2024 and $65,209,000 in fiscal year 2025.

Subd. 19. **Grant Programs; Health Care Grants**

Appropriations by Fund		
	2022	2023
General Fund	-0-	2,500,000
Health Care Access	1,936,000	64,000

(a) **Grant Funding to Support Urban American Indians in Minnesota Health Care Programs.** $2,500,000 in fiscal year 2023 is from the general fund for funding to the Indian Health Board of Minneapolis to support continued access to health care coverage through Minnesota health care programs, improve access to quality care, and increase vaccination rates among urban American Indians.

(b) **Grants for Navigator Organizations.** (1) $1,936,000 in fiscal year 2022 is from the health care access fund for grants to organizations with a MNsure grant services navigator assister contract in good standing as of June 30, 2022. The grants to each organization must be in proportion to the number of medical assistance and

MinnesotaCare enrollees each organization assisted that resulted in a successful enrollment in the second quarter of fiscal year 2020, as determined by MNsure's navigator payment process. This is a onetime appropriation and is available until June 30, 2025. (2) $64,000 in fiscal year 2023 is from the health care access fund for incentive payments as defined in Minnesota Statutes, section 256.962, subdivision 5. This appropriation is available until June 30, 2025. The general fund base for this appropriation is $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(c) **Base Level Adjustment.** The general fund base is increased $3,750,000 in fiscal year 2024 and $1,250,000 in fiscal year 2025. The health care access fund base is increased $1,000,000 in fiscal year 2024, and $0 in fiscal year 2025.

Subd. 20. **Grant Programs; Other Long-Term Care Grants** -0- 119,336,000

(a) **Workforce Incentive Fund Grant Program.** $118,000,000 in fiscal year 2023 is to assist disability, housing, substance use, and older adult service providers of public programs to pay for incentive benefits to current and new workers. This is a onetime appropriation and is available until June 30, 2025. Three percent of the total amount of the appropriation may be used to administer the program, which could include contracting with a third-party administrator.

(b) **Supported Decision Making.** $600,000 in fiscal year 2023 is for a grant to Volunteers

for America for the Centers for Excellence in Supported Decision Making to assist older adults and people with disabilities in avoiding unnecessary guardianships through using less restrictive alternatives, such as supported decision making. The base for this appropriation is $600,000 in fiscal year 2024, $600,000 in fiscal year 2025, and $0 in fiscal year 2026.

(c) **Support Coordination Training.** $736,000 in fiscal year 2023 is to develop and implement a curriculum and training plan for case managers to ensure all case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for people who use home and community-based disability services waivers authorized under Minnesota Statutes, sections 256B.0913, 256B.092, and 256B.49, and chapter 256S, and live in own-home settings. Case manager support planning and coordination responsibilities to be addressed in the training include developing a plan with the participant and their family to address urgent staffing changes or unavailability and other support coordination issues that may arise for a participant. The commissioner shall work with lead agencies, advocacy organizations, and other stakeholders to develop the training. An initial support coordination training and competency evaluation must be completed by all staff responsible for case management, and the support coordination training and competency evaluation must be available to all staff responsible for case management following

the initial training. The base for this appropriation is $377,000 in fiscal year 2024, $377,000 in fiscal year 2025, and $0 in fiscal year 2026.

(d) **Base Level Adjustment.** The general fund base is increased $977,000 in fiscal year 2024 and $977,000 in fiscal year 2025.

Subd. 21. **Grant Programs; Disabilities Grants** -0- 8,950,000

(a) **Electronic Visit Verification (EVV) Stipends.** $6,440,000 in fiscal year 2023 is for onetime stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access EVV. $5,600,000 of the appropriation is for stipends and the remaining 15 percent is for administration of these stipends. This is a onetime appropriation.

(b) **Self-Directed Collective Bargaining Agreement; Temporary Rate Increase Memorandum of Understanding.** $1,610,000 in fiscal year 2023 is for onetime stipends for individual providers covered by the SEIU collective bargaining agreement based on the memorandum of understanding related to the temporary rate increase in effect between December 1, 2020, and February 7, 2021. $1,400,000 of the appropriation is for stipends and the remaining 15 percent is for administration of the stipends. This is a onetime appropriation.

(c) **Service Employees International Union Memorandums.** The memorandums of understanding submitted by the commissioner of management and budget to the Legislative

Coordinating Commission Subcommittee on Employee Relations on March 17, 2022, are ratified.

(d) **Direct Care Service Corps Pilot Project.** $500,000 in fiscal year 2023 is for a grant to HealthForce Minnesota at Winona State University for purposes of the direct care service corps pilot project in this act. Up to $25,000 may be used by HealthForce Minnesota for administrative costs. This is a onetime appropriation.

(e) **Task Force on Disability Services Accessibility.** $250,000 in fiscal year 2023 is for the Task Force on Disability Services Accessibility. Of this amount, $..... must be used to provide pilot project grants. This is a onetime appropriation and is available until March 31, 2026.

(f) **Base Level Adjustment.** The general fund base is increased $805,000 in fiscal year 2024 and $2,420,000 in fiscal year 2025.

Subd. 22. **Grant Programs; Adult Mental Health Grants** 20,000,000 33,280,000

(a) **Inpatient Psychiatric and Psychiatric Residential Treatment Facilities.** $10,000,000 in fiscal year 2023 is for competitive grants to hospitals or mental health providers to retain, build, or expand children's inpatient psychiatric beds for children in need of acute high-level psychiatric care or psychiatric residential treatment facility beds as described in Minnesota Statutes, section 256B.0941. In order to be eligible for a grant, a hospital or mental health provider must serve individuals covered by medical

assistance under Minnesota Statutes, section 256B.0625.

(b) **Expanding Support for Psychiatric Residential Treatment Facilities.** $800,000 in fiscal year 2023 is for start-up grants to psychiatric residential treatment facilities as described in Minnesota Statutes, section 256B.0941. Grantees can use grant money for emergency workforce shortage uses. Allowable grant uses related to emergency workforce shortages may include but are not limited to hiring and retention bonuses, recruitment of a culturally responsive workforce, and allowing providers to increase the hourly rate in order to be competitive in the market.

(c) **Workforce Incentive Fund Grant Program.** $20,000,000 in fiscal year 2022 is to provide mental health public program providers the ability to pay for incentive benefits to current and new workers. This is a onetime appropriation and is available until June 30, 2025. Three percent of the total amount of the appropriation may be used to administer the program, which may include contracting with a third-party administrator.

(d) **Cultural and Ethnic Infrastructure Grant Funding.** $10,000,000 in fiscal year 2023 is for increasing cultural and ethnic infrastructure grant funding under Minnesota Statutes, section 245.4903. The base for this appropriation is $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025.

(e) **Mental Health Provider Grants to Rural and Underserved Communities.** $5,000,000

in fiscal year 2023 is for a grant program to recruit mental health providers in rural areas and underserved communities. This money may be used for reimbursement of supervision costs of interns and clinical trainees, reimbursing staff for master's degree tuition costs in mental health fields, and licensing and exam fees.

(f) **Culturally Specific Grants.** $2,000,000 in fiscal year 2023 is for grants for small to midsize nonprofit organizations who represent and support American Indian, Indigenous, and other communities disproportionately affected by the opiate crisis. These grants utilize traditional healing practices and other culturally congruent and relevant supports to prevent and curb opiate use disorders through housing, treatment, education, aftercare, and other activities as determined by the commissioner. The base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(g) **African American Community Mental Health Center Grant.** $1,000,000 in fiscal year 2023 is for a grant to an African American mental health service provider that is a licensed community mental health center specializing in services for African American children and families. The center must offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder services; supervision and training; and care coordination to all ages, regardless of ability

to pay or place of residence. Upon request, the commissioner shall make information regarding the use of this grant funding available to the chairs and ranking minority members of the committees with jurisdiction over human services. This is a onetime appropriation.

(h) **Behavioral Health Peer Training.** $1,000,000 in fiscal year 2023 is for training and development for mental health certified peer specialists, mental health certified family peer specialists, and recovery peer specialists. Training and development may include but is not limited to initial training and certification.

(i) **Intensive Residential Treatment Services Locked Facilities.** $2,796,000 in fiscal year 2023 is for start-up funds to intensive residential treatment service providers to provide treatment in locked facilities for patients who have been transferred from a jail or who have been deemed incompetent to stand trial and a judge has determined that the patient needs to be in a secure facility. This is a onetime appropriation.

(j) **Base Level Adjustment.** The general fund base is increased $32,092,000 in fiscal year 2024 and $39,216,000 in fiscal year 2025. The opiate epidemic response base is increased $2,000,000 in fiscal year 2025.

Subd. 23. **Grant Programs; Child Mental Health Grants** -0- 16,396,000

(a) **First Episode of Psychosis Grants.** $300,000 in fiscal year 2023 is for first episode of psychosis grants under Minnesota Statutes, section 245.4905.

(b) **Children's Residential Treatment Services Emergency Funding.** $2,500,000 in fiscal year 2023 is from the general fund to provide licensed children's residential treatment facilities with emergency funding for staff overtime, one-to-one staffing as needed, staff recruitment and retention, and training and related costs to maintain quality staff. Up to $500,000 of this appropriation may be allocated to support group home organizations supporting children transitioning to lower levels of care. This is a onetime appropriation.

(c) **Children's Residential Facility Crisis Stabilization.** $3,000,000 in fiscal year 2023 is for implementing children's residential facility crisis stabilization services licensing requirements and reimbursing county costs for children's residential crisis stabilization services as required under Minnesota Statutes, section 245.4882, subdivision 6.

(d) **Base Level Adjustment.** The general fund base is increased $16,100,000 in fiscal year 2024 and $1,100,000 in fiscal year 2025.

Subd. 24. **Grant Programs; Chemical Dependency Treatment Support Grants** -0- 2,000,000

(a) **Emerging Mood Disorder Grant Program.** $1,000,000 in fiscal year 2023 is for emerging mood disorder grants under Minnesota Statutes, section 245.4904. Grantees must use grant money as required in Minnesota Statutes, section 245.4904, subdivision 2.

(b) **Substance Use Disorder Treatment and Prevention Grants.** The base shall include

$4,000,000 in fiscal year 2024 and $4,000,000 in fiscal year 2025 for substance use disorder treatment and prevention grants recommended by the substance use disorder advisory council.

(c) **Traditional Healing Grants.** The base shall include $2,000,000 in fiscal year 2025 to extend the traditional healing grant funding appropriated in Laws 2019, chapter 63, article 3, section 1, paragraph (h), from the opiate epidemic response account to the commissioner of human services. This funding is awarded to all Tribal nations and to five urban Indian communities for traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(d) **Base Level Adjustment.** The general fund base is increased $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025.

Subd. 25. **Direct Care and Treatment - Operations**	-0-	6,501,000

Base Level Adjustment. The general fund base is increased $5,267,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 26. **Technical Activities**	-0-	-0-

(a) **Transfers; Child Care and Development Fund.** For fiscal years 2024 and 2025, the base shall include a transfer of $23,500,000 in fiscal year 2024 and $23,500,000 in fiscal year 2025 from the TANF fund to the child care and development fund. These are onetime transfers.

(b) **Base Level Adjustment.** The TANF base is increased $23,500,000 in fiscal year 2024,

$23,500,000 in fiscal year 2025, and $0 in fiscal year 2026.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$ 266,597,000**

Appropriations by Fund

	2022	2023
General	-0-	260,127,000
State Government Special Revenue	-0-	4,895,000
Health Care Access	-0-	21,575,000

Subd. 2. **Health Improvement**

Appropriations by Fund

General	-0-	182,977,000
State Government Special Revenue	-0-	509,000
Health Care Access	-0-	21,575,000

(a) **988 National Suicide Prevention Lifeline.** $8,671,000 in fiscal year 2023 is from the general fund for 988 suicide prevention lifeline grants in Minnesota Statutes, section 145.56. The general fund base for this appropriation is $10,014,000 in fiscal year 2024 and $10,014,000 in fiscal year 2025.

(b) **Address Growing Health Care Costs.** $3,375,000 in fiscal year 2023 is from the general fund for initiatives aimed at addressing growth in health care spending while ensuring stability in rural health care programs. The general fund base for this appropriation is $4,175,000 in fiscal year 2024, and $4,175,000 in fiscal year 2025.

(c) **Community Health Workers.** $1,462,000 in fiscal year 2023 is from the general fund for a public health approach to developing community health workers across Minnesota,

under Minnesota Statutes, section 145.9282. Of this appropriation, $462,000 is for administration and $1,000,000 is for grants. The general fund base for this appropriation is $1,097,000 in fiscal year 2024, of which $337,000 is for administration and $760,000 is for grants, and $1,098,000 in fiscal year 2025, of which $338,000 is for administration and $760,000 is for grants.

(d) **Community Solutions for Healthy Child Development.** $10,000,000 in fiscal year 2023 is from the general fund for the community solutions for healthy child development grant program under Minnesota Statutes, section 145.9271. Of this appropriation, $1,250,000 is for administration and $8,750,000 is for grants. The general fund base appropriation is $10,000,000 in fiscal year 2024 and $10,000,000 in fiscal year 2025, of which $1,250,000 is for administration and $8,750,000 is for grants in each fiscal year.

(e) **Disability as a Health Equity Issue.** $1,575,000 in fiscal year 2023 is from the general fund to reduce disability-related health disparities through collaboration and coordination between state and community partners under Minnesota Statutes, section 145.9283. Of this appropriation, $1,130,000 is for administration and $445,000 is for grants. The general fund base for this appropriation is $1,585,000 in fiscal year 2024 and $1,585,000 in fiscal year 2025, of which $1,140,000 is for administration and $445,000 is for grants.

(f) **Drug Overdose and Substance Abuse Prevention.** $5,042,000 in fiscal year 2023 is from the general fund for a public health prevention approach to drug overdose and substance use disorder in Minnesota Statutes, section 144.8611. Of this appropriation, $921,000 is for administration and $4,121,000 is for grants.

(g) **Healthy Beginnings, Healthy Families.** $11,700,000 in fiscal year 2023 is from the general fund for Healthy Beginnings, Healthy Families services under Minnesota Statutes, section 145.987. The general fund base for this appropriation is $11,818,000 in fiscal year 2024 and $11,763,000 in fiscal year 2025. Of this appropriation:

(1) $7,510,000 in fiscal year 2023 is for the Minnesota Collaborative to Prevent Infant Mortality under Minnesota Statutes, section 145.987, subdivisions 2, 3, and 4, of which $1,535,000 is for administration and $5,975,000 is for grants. The general fund base for this appropriation is $7,501,000 in fiscal year 2024, of which $1,526,000 is for administration and $5,975,000 is for grants, and $7,501,000 in fiscal year 2025, of which $1,526,000 is for administration and $5,975,000 is for grants.

(2) $340,000 in fiscal year 2023 is for Help Me Connect under Minnesota Statutes, section 145.987, subdivisions 5 and 6. The general fund base for this appropriation is $663,000 in fiscal year 2024 and $663,000 in fiscal year 2025.

(3) $1,940,000 in fiscal year 2023 is for voluntary developmental and social-emotional screening and follow-up under Minnesota Statutes, section 145.987, subdivisions 7 and 8, of which $1,190,000 is for administration and $750,000 is for grants. The general fund base for this appropriation is $1,764,000 in fiscal year 2024, of which $1,014,000 is for administration and $750,000 is for grants, and $1,764,000 in fiscal year 2025, of which $1,014,000 is for administration and $750,000 is for grants.

(4) $1,910,000 in fiscal year 2023 is for model jail practices for incarcerated parents under Minnesota Statutes, section 145.987, subdivisions 9, 10, and 11, of which $485,000 is for administration and $1,425,000 is for grants. The general fund base for this appropriation is $1,890,000 in fiscal year 2024, of which $465,000 is for administration and $1,425,000 is for grants, and $1,835,000 in fiscal year 2025, of which $410,000 is for administration and $1,425,000 is for grants.

(h) **Home Visiting.** $62,386,000 in fiscal year 2023 is from the general fund for universal, voluntary home visiting services under Minnesota Statutes, section 145.871. Of this appropriation, ten percent is for administration and 90 percent is for implementation grants of home visiting services to families. The general fund base for this appropriation is $63,386,000 in fiscal year 2024 and $63,386,000 in fiscal year 2025.

(i) **Long COVID.** $2,669,000 in fiscal year 2023 is from the general fund for a public

health approach to supporting long COVID survivors under Minnesota Statutes, section 145.361. Of this appropriation, $2,119,000 is for administration and $550,000 is for grants. The base for this appropriation is $3,706,000 in fiscal year 2024 and $3,706,000 in fiscal year 2025, of which $3,156,000 is for administration and $550,000 is for grants in each fiscal year.

(j) **Medical Education Research Cost (MERC).** Of the amount previously appropriated in the general fund by Laws 2015, chapter 71, article 3, section 2, for the MERC program, $150,000 in fiscal year 2023 and each year thereafter is for the administration of grants under Minnesota Statutes, section 62J.692.

(k) **No Surprises Act Enforcement.** $964,000 in fiscal year 2023 is from the general fund for implementation of the federal No Surprises Act portion of the Consolidated Appropriations Act, 2021, under Minnesota Statutes, section 62Q.021, subdivision 3. The general fund base for this appropriation is $763,000 in fiscal year 2024 and $757,000 in fiscal year 2025.

(l) **Public Health System Transformation.** $23,531,000 in fiscal year 2023 is from the general fund for public health system transformation. Of this appropriation:

(1) $20,000,000 is for grants to community health boards under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (f).

(2) $1,000,000 is for grants to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2b.

(3) $1,000,000 is for a public health AmeriCorps program grant under Minnesota Statutes, section 145.9292.

(4) $1,531,000 is for the commissioner to oversee and administer activities under this paragraph.

(m) **Revitalize Health Care Workforce.** $21,575,000 in fiscal year 2023 is from the health care access fund to address challenges of Minnesota's health care workforce. Of this appropriation:

(1) $2,073,000 in fiscal year 2023 is for the health professionals clinical training expansion and rural and underserved clinical rotations grant programs under Minnesota Statutes, section 144.1505, of which $423,000 is for administration and $1,650,000 is for grants. Grant appropriations are available until expended under Minnesota Statutes, section 144.1505, subdivision 2.

(2) $4,507,000 in fiscal year 2023 is for the primary care rural residency training grant program under Minnesota Statutes, section 144.1507, of which $207,000 is for administration and $4,300,000 is for grants. Grant appropriations are available until expended under Minnesota Statutes, section 144.1507, subdivision 2.

(3) $430,000 in fiscal year 2023 is for the international medical graduates assistance program under Minnesota Statutes, section

144.1911, for international immigrant medical graduates to fill a gap in their preparedness for medical residencies or transition to a new career making use of their medical degrees. Of this appropriation, $55,000 is for administration and $375,000 is for grants.

(4) $12,565,000 in fiscal year 2023 is for a grant program to health care systems, hospitals, clinics, and other providers to ensure the availability of clinical training for students, residents, and graduate students to meet health professions educational requirements, under Minnesota Statutes, section 144.1511, of which $565,000 is for administration and $12,000,000 is for grants.

(5) $2,000,000 in fiscal year 2023 is for the mental health cultural community continuing education grant program, of which $460,000 is for administration and $1,540,000 is for grants.

(n) **School Health.** $837,000 in fiscal year 2023 is from the general fund for the School Health Initiative under Minnesota Statutes, section 145.988. The general fund base for this appropriation is $3,462,000 in fiscal year 2024, of which $1,212,000 is for administration and $2,250,000 is for grants and $3,287,000 in fiscal year 2025, of which $1,037,000 is for administration and $2,250,000 is for grants.

(o) **Trauma System.** $61,000 in fiscal year 2023 is from the general fund to administer the trauma care system throughout the state under Minnesota Statutes, sections 144.602, 144.603, 144.604, 144.606, and 144.608.

$430,000 in fiscal year 2023 is from the state government special revenue fund for trauma designations per Minnesota Statutes, sections 144.122, paragraph (g), 144.605, and 144.6071.

(p) **Mental Health Providers; Loan Forgiveness, Grants, Information Clearinghouse.** $3,275,000 in fiscal year 2023 is from the general fund for activities to increase the number of mental health professionals in the state. Of this appropriation:

(1) $1,000,000 is for loan forgiveness under the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, notwithstanding the priorities and distribution requirements in that section, for eligible mental health professionals who provide clinical supervision in their designated field;

(2) $2,000,000 is for the mental health provider supervision grant program under Minnesota Statutes, section 144.1508;

(3) $250,000 is for the mental health professional scholarship grant program under Minnesota Statutes, section 144.1509; and

(4) $25,000 is for the commissioner to establish and maintain a website to serve as an information clearinghouse for mental health professionals and individuals seeking to qualify as a mental health professional. The website must contain information on the various master's level programs to become a mental health professional, requirements for

supervision, where to find supervision, how to access tools to study for the applicable licensing examination, links to loan forgiveness programs and tuition reimbursement programs, and other topics of use to individuals seeking to become a mental health professional. This is a onetime appropriation.

(q) **Palliative Care Advisory Council.** $44,000 in fiscal year 2023 is from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059.

(r) **Emmett Louis Till Victims Recovery Program.** $500,000 in fiscal year 2023 is from the general fund for the Emmett Louis Till Victims Recovery Program. This is a onetime appropriation and is available until June 30, 2024.

(s) **Changes to Birth Certificates.** $75,000 in fiscal year 2023 is from the state government special revenue fund for implementation of Minnesota Statutes, section 144.2182. The state government special revenue fund base for this appropriation is $7,000 in fiscal year 2024 and $7,000 in fiscal year 2025.

(t) **Study; POLST Forms.** $292,000 in fiscal year 2023 is from the general fund for the commissioner to study the creation of a statewide registry of provider orders for life-sustaining treatment and issue a report and recommendations.

(u) **Benefit and Cost Analysis of Universal Health Reform Proposal.** $461,000 in fiscal

year 2023 is from the general fund for a contract for an analysis of the benefits and costs of a universal health care financing system and a similar analysis of the current health care financing system. The general fund base for this appropriation is $288,000 in fiscal year 2024 and $0 in 2025.

(v) **Technical Assistance; Health Care Trends and Costs.** $5,000,000 in fiscal year 2023 is from the general fund for technical assistance to the Health Care Affordability Board in analyzing health care trends and costs and setting health care spending growth targets.

(w) **Base Level Adjustments.** The general fund base is increased $181,679,000 in fiscal year 2024 and $181,156,000 in fiscal year 2025. The health care access fund base is increased $21,575,000 in fiscal year 2024 and $21,575,000 in fiscal year 2025. The state government special revenue fund base is increased $437,000 in fiscal year 2024 and $437,000 in fiscal year 2025.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	-0-	77,150,000
State Government Special Revenue	-0-	4,386,000

(a) **Climate Resiliency.** $1,977,000 in fiscal year 2023 is from the general fund for climate resiliency actions under Minnesota Statutes, section 144.9981. Of this appropriation, $977,000 is for administration and $1,000,000 is for grants. The general fund base for this appropriation is $988,000 in fiscal year 2024,

of which $888,000 is for administration and $100,000 is for grants, and $989,000 in fiscal year 2025, of which $889,000 is for administration and $100,000 is for grants.

(b) **Lead Remediation in Schools and Child Care Settings.** $2,054,000 in fiscal year 2023 is from the general fund for a lead in drinking water remediation in schools and child care settings grant program under Minnesota Statutes, section 145.9272. Of this appropriation, $454,000 is for administration and $1,600,000 is for grants. The general fund base for this appropriation is $1,540,000 in fiscal year 2024, of which $370,000 is for administration and $1,170,000 is for grants, and $1,541,000 in fiscal year 2025, of which $371,000 is for administration and $1,170,000 is for grants.

(c) **Lead Service Line Inventory.** $4,029,000 in fiscal year 2023 is from the general fund for grants to public water suppliers to complete a lead service line inventory of their distribution systems under Minnesota Statutes, section 144.383, clause (6). Of this appropriation, $279,000 is for administration and $3,750,000 is for grants. The general fund base for this appropriation is $4,029,000 in fiscal year 2024, of which $279,000 is for administration and $3,750,000 is for grants, and $140,000 in fiscal year 2025, which is for administration.

(d) **Lead Service Line Replacement.** $5,000,000 in fiscal year 2023 is from the general fund for administrative costs related

to the replacement of lead service lines in the state.

(e) **Mercury in Skin-Lightening Products Grants.** $100,000 in fiscal year 2023 is from the general fund for a skin-lightening products public awareness and education grant program under Minnesota Statutes, section 145.9275.

(f) **HIV Prevention for People Experiencing Homelessness.** $1,129,000 in fiscal year 2023 is from the general fund for expanding access to harm reduction services and improving linkages to care to prevent HIV/AIDS, hepatitis, and other infectious diseases for those experiencing homelessness or housing instability under Minnesota Statutes, section 145.924, paragraph (d). Of this appropriation, $169,000 is for administration and $960,000 is for grants.

(g) **Safety Improvements for State-Licensed Long-Term Care Facilities.** $5,500,000 in fiscal year 2023 is from the general fund for a temporary grant program for safety improvements for state-licensed long-term care facilities. Of this appropriation, $500,000 is for administration and $5,000,000 is for grants. The general fund base for this appropriation is $8,200,000 in fiscal year 2024 and $0 in fiscal year 2025. Of this appropriation in fiscal year 2024, $700,000 is for administration and $7,500,000 is for grants. This appropriation is available until June 30, 2025.

(h) **Sexual Exploitation and Trafficking Study.** $300,000 in fiscal year 2023 is to fund a prevalence study on youth and adult victim

survivors of sexual exploitation and trafficking. This is a onetime appropriation and is available until June 30, 2024.

(i) **Mortuary Science.** $219,000 in fiscal year 2023 is from the state government special revenue fund for regulation of transfer care specialists under Minnesota Statutes, chapter 149A, and for additional reporting requirements under Minnesota Statutes, section 149A.94. The state government special revenue fund base for this appropriation is $132,000 in fiscal year 2024 and $61,000 in fiscal year 2025.

(j) **Drinking Water Lead Testing and Remediation; Day Care Facilities.** $1,000,000 in fiscal year 2023 is from the general fund for statewide testing of day care facilities for the presence of lead in drinking water and for remediation of contamination where found.

(k) **Local and Tribal Public Health Emergency Preparedness and Response.** $9,000,000 in fiscal year 2023 is from the general fund for distribution to local and Tribal public health organizations for emergency preparedness and response capabilities. At least 90 percent of this appropriation must be distributed to local and Tribal public health organizations, and up to ten percent of this appropriation may be used by the commissioner for administrative costs. Use of this appropriation must align with the Centers for Disease Control and Prevention's issued report, Public Health Emergency Preparedness and Response Capabilities: National Standards

for State, Local, Tribal, and Territorial Public Health.

(l) **Grants to Local Public Health Departments.** $16,172,000 in fiscal year 2023 is from the general fund for grants to local public health departments for public health response related to defining elevated blood lead level as 3.5 micrograms of lead or greater per deciliter of whole blood. Of this amount, $172,000 is available to the commissioner for administrative costs. This appropriation is available until June 30, 2025. The general fund base for this appropriation is $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025.

(m) **Loan Forgiveness for Nursing Instructors.** Notwithstanding the priorities and distribution requirements in Minnesota Statutes, section 144.1501, $50,000 in fiscal year 2023 is from the general fund for loan forgiveness under the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, for eligible nurses who agree to teach.

(n) **Mental Health of Health Care Workers.** $1,000,000 in fiscal year 2023 is from the general fund for competitive grants to hospitals, community health centers, rural health clinics, and medical professional associations to establish or enhance evidence-based or evidence-informed programs dedicated to improving the mental health of health care professionals.

(o) **Prevention of Violence in Health Care.** $50,000 in fiscal year 2023 is from the general

fund to continue the prevention of violence in health care programs and to create violence prevention resources for hospitals and other health care providers to use to train their staff on violence prevention.

(p) **Hospital Nursing Loan Forgiveness.** $5,000,000 in fiscal year 2023 is from the general fund for the hospital nursing loan forgiveness program under Minnesota Statutes, section 144.1504.

(q) **Program to Distribute COVID-19 Tests, Masks, and Respirators.** $15,000,000 in fiscal year 2023 is from the general fund for a program to distribute COVID-19 tests, masks, and respirators to individuals in the state. This is a onetime appropriation.

(r) **Safe Harbor Grants.** $1,000,000 in fiscal year 2023 is for grants to fund supportive services including but not limited to legal services, mental health therapy, substance use disorder counseling, and case management for sexually exploited youth or youth at risk of sexual exploitation under Minnesota Statutes, section 145.4716.

(s) **Safe Harbor Regional Navigators.** $700,000 in fiscal year 2023 is for safe harbor regional navigators under Minnesota Statutes, section 145.4717.

(t) **Public Health Response Contingency Account.** $20,000,000 in fiscal year 2023 is from the general fund for transfer to the public health response contingency account under Minnesota Statutes, section 144.4199.

(u) **Base Level Adjustments.** The general fund base is increased $32,206,000 in fiscal year 2024 and $20,021,000 in fiscal year 2025. The state government special revenue fund base is increased $4,299,000 in fiscal year 2024 and $4,288,000 in fiscal year 2025.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$**	**203,000**

Appropriations by Fund

General Fund	-0-	175,000
State Government Special Revenue	-0-	28,000

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Dentistry**	-0-	3,000
Subd. 3. **Board of Dietetics and Nutrition Practice**	-0-	25,000
Subd. 4. **Board of Pharmacy**	-0-	175,000

This appropriation is from the general fund.

Medication repository program. $175,000 in fiscal year 2023 is from the general fund for transfer by the Board of Pharmacy to the central repository to be used to administer the medication repository program according to the contract between the central repository and the Board of Pharmacy.

Sec. 5. **COUNCIL ON DISABILITY**	**$**	**-0-**	**$**	**375,000**
Sec. 6. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$**	**-0-**	**$**	**200,000**

This is a onetime appropriation.

Sec. 7. **BOARD OF DIRECTORS OF MNSURE** **$ -0- $ 7,775,000**

This appropriation may be transferred to the MNsure account established in Minnesota Statutes, section 62V.07.

Base Adjustment. The general fund base for this appropriation is $10,982,000 in fiscal year 2024, $6,450,000 in fiscal year 2025, and $0 in fiscal year 2026.

Sec. 8. **HEALTH CARE AFFORDABILITY BOARD.** **$ -0- $ 1,000,000**

(a) **Health Care Affordability Board.** $1,000,000 in fiscal year 2023 is from the general fund for the Health Care Affordability Board to implement Minnesota Statutes, sections 62J.86 to 62J.72.

(b) **Base Level Adjustment.** The general fund base is increased $500,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025.

Sec. 9. **COMMISSIONER OF COMMERCE** **$ -0- $ 251,000**

(a) **Prescription Drug Affordability Board.** $197,000 in fiscal year 2023 is from the general fund for the commissioner of commerce to establish the Prescription Drug Affordability Board under Minnesota Statutes, section 62J.87, and for the Prescription Drug Affordability Board to implement the Prescription Drug Affordability Act. Following the first meeting of the board and prior to June 30, 2023, the commissioner of commerce shall transfer any funds remaining from this appropriation to the board. The general fund base for this appropriation is $357,000 in fiscal year 2024 and $357,000 in fiscal year 2025.

(b) **Ectodermal Dysplasias.** $54,000 in fiscal year 2023 is from the general fund for costs related to insurance coverage of ectodermal dysplasias. The general fund base for this appropriation is $58,000 in fiscal year 2024 and $62,000 in fiscal year 2025.

Sec. 10. **COMMISSIONER OF LABOR AND INDUSTRY** **$ -0- $ 641,000**

Nursing Home Workforce Standards Board. $641,000 in fiscal year 2023 is for establishment and operation of the Nursing Home Workforce Standards Board in Minnesota Statutes, sections 181.211 to 181.217. The general fund base for this appropriation is $322,000 in fiscal year 2024 and $368,000 in fiscal year 2025.

Sec. 11. **ATTORNEY GENERAL** **$ -0- $ 456,000**

(a) **Expert Witnesses.** $200,000 in fiscal year 2023 is for expert witnesses and investigations under Minnesota Statutes, section 62J.844. This is a onetime appropriation.

(b) **Prescription Drug Enforcement.** $256,000 in fiscal year 2023 is for prescription drug enforcement. This is a onetime appropriation.

Sec. 12. Laws 2021, First Special Session chapter 2, article 1, section 4, subdivision 2, is amended to read:

Subd. 2. **Operations and Maintenance** 621,968,000 621,968,000

(a) $15,000,000 in fiscal year 2022 and $15,000,000 in fiscal year 2023 are to: (1) increase the medical school's research capacity; (2) improve the medical school's ranking in National Institutes of Health

funding; (3) ensure the medical school's national prominence by attracting and retaining world-class faculty, staff, and students; (4) invest in physician training programs in rural and underserved communities; and (5) translate the medical school's research discoveries into new treatments and cures to improve the health of Minnesotans.

(b) $7,800,000 in fiscal year 2022 and $7,800,000 in fiscal year 2023 are for health training restoration. This appropriation must be used to support all of the following: (1) faculty physicians who teach at eight residency program sites, including medical resident and student training programs in the Department of Family Medicine; (2) the Mobile Dental Clinic; and (3) expansion of geriatric education and family programs.

(c) $4,000,000 in fiscal year 2022 and $4,000,000 in fiscal year 2023 are for the Minnesota Discovery, Research, and InnoVation Economy funding program for cancer care research.

(d) $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are for the University of Minnesota, Morris branch, to cover the costs of tuition waivers under Minnesota Statutes, section 137.16.

(e) $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are for the Chloe Barnes Advisory Council on Rare Diseases under Minnesota Statutes, section 137.68. The fiscal year 2023 appropriation shall be transferred to the Council on Disability. The base for this

appropriation is $0 in fiscal year 2024 and later.

(f) The total operations and maintenance base for fiscal year 2024 and later is $620,818,000.

Sec. 13. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 29, is amended to read:

Subd. 29. **Grant Programs; Disabilities Grants**		31,398,000	31,010,000

(a) **Training Stipends for Direct Support Services Providers.** $1,000,000 in fiscal year 2022 is from the general fund for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Parent-to-Parent Peer Support.** $125,000 in fiscal year 2022 and $125,000 in fiscal year 2023 are from the general fund for a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for

families of children with a disability or special health care need.

(c) **Self-Advocacy Grants.** (1) $143,000 in fiscal year 2022 and $143,000 in fiscal year 2023 are from the general fund for a grant under Minnesota Statutes, section 256.477, subdivision 1.

(2) $105,000 in fiscal year 2022 and $105,000 in fiscal year 2023 are from the general fund for subgrants under Minnesota Statutes, section 256.477, subdivision 2.

(d) **Minnesota Inclusion Initiative Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants under Minnesota Statutes, section 256.4772.

(e) **Grants to Expand Access to Child Care for Children with Disabilities.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for grants to expand access to child care for children with disabilities. Any unspent amount in fiscal year 2022 is available through June 30, 2023. This is a onetime appropriation.

(f) **Parenting with a Disability Pilot Project.** The general fund base includes $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025 to implement the parenting with a disability pilot project.

(g) **Base Level Adjustment.** The general fund base is $29,260,000 in fiscal year 2024 and $22,260,000 in fiscal year 2025.

Sec. 14. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 31, is amended to read:

Subd. 31. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	98,772,000	98,703,000
Opiate Epidemic Response	2,000,000	2,000,000

(a) **Culturally and Linguistically Appropriate Services Implementation Grants.** $2,275,000 in fiscal year 2022 and $2,206,000 in fiscal year 2023 are from the general fund for grants to disability services, mental health, and substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation and transition plan developed by the commissioner. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $1,655,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) **Base Level Adjustment.** The general fund base is $93,295,000 in fiscal year 2024 and $83,324,000 in fiscal year 2025. The opiate epidemic response fund base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 15. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	4,273,000	4,274,000

Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	500,000

(a) **Problem Gambling.** $225,000 in fiscal year 2022 and $225,000 in fiscal year 2023 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Recovery Community Organization Grants.** $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the general fund for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide for costs and community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05, as part of the continuum of care for substance use disorders. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025

(c) **Base Level Adjustment.** The general fund base is $4,636,000 in fiscal year 2024 and $2,636,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 16. Laws 2021, First Special Session chapter 7, article 17, section 3, is amended to read:

Sec. 3. **GRANTS FOR TECHNOLOGY FOR HCBS RECIPIENTS.**

(a) This act includes $500,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to issue competitive grants to home and community-based service providers. Grants must be used to provide technology assistance, including but not limited to Internet services, to older adults and people with disabilities who do not have access to technology resources necessary to use remote service delivery and telehealth. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,500,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

Sec. 17. Laws 2021, First Special Session chapter 7, article 17, section 6, is amended to read:

Sec. 6. **TRANSITION TO COMMUNITY INITIATIVE.**

(a) This act includes $5,500,000 in fiscal year 2022 and $5,500,000 in fiscal year 2023 for additional funding for grants awarded under the transition to community initiative described in Minnesota Statutes, section 256.478. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $4,125,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

Sec. 18. Laws 2021, First Special Session chapter 7, article 17, section 10, is amended to read:

Sec. 10. **PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED COMMUNITIES.**

(a) This act includes $6,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for the commissioner to establish a grant program for small provider organizations that provide services to rural or underserved communities with limited home and

community-based services provider capacity. The grants are available to build organizational capacity to provide home and community-based services in Minnesota and to build new or expanded infrastructure to access medical assistance reimbursement. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $8,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) The commissioner shall conduct community engagement, provide technical assistance, and establish a collaborative learning community related to the grants available under this section and work with the commissioner of management and budget and the commissioner of the Department of Administration to mitigate barriers in accessing grant funds. Funding awarded for the community engagement activities described in this paragraph is exempt from state solicitation requirements under Minnesota Statutes, section 16B.97, for activities that occur in fiscal year 2022.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

Sec. 19. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to read:

Sec. 11. **EXPAND MOBILE CRISIS.**

(a) This act includes $8,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for additional funding for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15). Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $4,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

Sec. 20. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to read:

Sec. 12. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD AND ADOLESCENT MOBILE TRANSITION UNIT.**

(a) This act includes $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for the commissioner of human services to create children's mental health transition and support teams to facilitate transition back to the community of children from psychiatric residential treatment facilities, and child and adolescent behavioral health hospitals. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) This section expires March 31, 2024.

Sec. 21. Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3, is amended to read:

Subd. 3. **Respite services for older adults grants.** (a) This act includes $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to establish a grant program for respite services for older adults. The commissioner must award grants on a competitive basis to respite service providers. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This subdivision expires June 30, 2024.

Sec. 22. **APPROPRIATIONS FOR ADVISORY COUNCIL ON RARE DISEASES.**

In accordance with Minnesota Statutes, section 15.039, subdivision 6, the unexpended balance of money appropriated from the general fund to the Board of Regents of the University of Minnesota for purposes of the advisory council on rare diseases under Minnesota Statutes, section 137.68, shall be under control of the Minnesota Rare Disease Advisory Council and the Council on Disability.

Sec. 23. **APPROPRIATION ENACTED MORE THAN ONCE.**

If an appropriation is enacted more than once in the 2022 legislative session, the appropriation must be given effect only once.

Sec. 24. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different effective date is explicit.

Sec. 25. **EFFECTIVE DATE.**

This article is effective the day following final enactment."

Delete the title and insert:

"A bill for an act

relating to health; changing provisions for health care and nursing facilities, hospital construction moratorium, radioactive material, ST elevation myocardial infarction response, health care coverage, cancer reporting system, lead hazard, safe drinking water, nursing home and health profession licensure, certain advisory councils, assisted living and home care providers, body art, medical cannabis, health care financing, certain health care and provider fees, certain health profession loan forgiveness programs, hospital core staffing plans, medical cannabis, certain grant programs; modifying certain definitions, hemp and edible cannabinoid product requirements, prohibition of discrimination in access to transplants, medical assistance eligibility and coverage, co-payments, report requirements, treatment of trusts, telehealth requirements, health-related licensing board requirements, practice of pharmacy, temporary ambulance service, prescription drug price reporting and public posting, drug administration, medication repository program, health insurance coverage; establishing certain advisory councils and boards, managed care opt-out, public MinnesotaCare option, climate resiliency program, long COVID program, national suicide prevention lifeline number, drug overdose and substance abuse prevention, ombudsperson for managed care, certain grants, school health initiative, Emmett Louis Till Victims Recovery, Keeping Nurses at the Bedside Act, registry for life-sustaining treatment orders; allowing change of sex designation; addressing health disparities; requiring balance billing and analysis of Universal Health Reform proposal; making forecast adjustments; providing for fees; providing civil penalties, requiring reports; amending Minnesota Statutes 2020, sections 34A.01, subdivision 4; 62A.02, subdivision 1; 62A.25, subdivision 2; 62A.28, subdivision 2; 62A.30, by adding a subdivision; 62J.2930, subdivision 3; 62J.84, as amended; 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56, subdivision 2; 62Q.73, subdivision 7; 62U.04, subdivision 11, by adding a subdivision; 62U.10, subdivision 7; 137.68; 144.1201, subdivisions 2, 4; 144.122; 144.1501, subdivision 4; 144.1503; 144.1505; 144.383; 144.497; 144.554; 144.565, subdivision 4; 144.586, by adding a subdivision; 144.6502, subdivision 1; 144.651, by adding a subdivision; 144.69; 144.7055; 144.9501, subdivisions 9, 26a, 26b; 144.9505, subdivisions 1, 1h; 144A.01; 144A.03, subdivision 1; 144A.04, subdivisions 4, 6; 144A.06; 144A.4799, subdivisions 1, 3; 144A.75, subdivision 12; 144G.08, by adding a subdivision; 144G.15; 144G.17; 144G.19, by adding a subdivision; 144G.20, subdivisions 1, 4, 5, 8, 9, 12, 15; 144G.30, subdivision 5; 144G.31, subdivisions 4, 8; 144G.41, subdivisions 7, 8; 144G.42, subdivision 10; 144G.50, subdivision 2; 144G.52, subdivisions 2, 8, 9; 144G.53; 144G.55, subdivisions 1, 3; 144G.56, subdivisions 3, 5; 144G.57,

subdivisions 1, 3, 5; 144G.70, subdivisions 2, 4; 144G.80, subdivision 2; 144G.90, subdivision 1; 144G.91, subdivisions 13, 21, by adding a subdivision; 144G.92, subdivision 1; 144G.93; 144G.95; 145.56, by adding subdivisions; 145.924; 145A.131, subdivisions 1, 5; 145A.14, by adding a subdivision; 146B.04, subdivision 1; 148B.33, by adding a subdivision; 148E.100, subdivision 3; 148E.105, subdivision 3; 148E.106, subdivision 3; 148E.110, subdivision 7; 149A.01, subdivisions 2, 3; 149A.02, subdivision 13a, by adding subdivisions; 149A.03; 149A.09; 149A.11; 149A.60; 149A.61, subdivisions 4, 5; 149A.62; 149A.63; 149A.65, subdivision 2; 149A.70, subdivisions 3, 4, 5, 7; 149A.90, subdivisions 2, 4, 5; 149A.94, subdivision 1; 150A.06, subdivisions 1c, 2c, 6, by adding a subdivision; 150A.09; 150A.091, subdivisions 2, 5, 8, 9, by adding subdivisions; 151.01, subdivisions 23, 27, by adding subdivisions; 151.071, subdivisions 1, 2; 151.37, by adding a subdivision; 151.555, as amended; 151.72, subdivisions 1, 2, 3, 4, 6, by adding a subdivision; 152.01, subdivision 23; 152.02, subdivisions 2, 3; 152.11, by adding a subdivision; 152.12, by adding a subdivision; 152.125; 152.22, subdivision 8, by adding subdivisions; 152.25, subdivision 1, by adding a subdivision; 152.29, subdivisions 3a, 4, by adding a subdivision; 152.30; 152.32; 152.33, subdivision 1; 152.35; 152.36; 153.16, subdivision 1; 256B.021, subdivision 4; 256B.055, subdivisions 2, 17; 256B.056, subdivisions 3, 3b, 3c, 4, 7, 11; 256B.0595, subdivision 1; 256B.0625, subdivisions 13f, 17a, 22, 28b, 64, by adding subdivisions; 256B.0631, as amended; 256B.69, subdivisions 4, 5c, 28, 36; 256B.692, subdivision 1; 256B.6925, subdivisions 1, 2; 256B.6928, subdivision 3; 256B.76, subdivision 1; 256B.77, subdivision 13; 256L.03, subdivisions 1a, 5; 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision; Minnesota Statutes 2021 Supplement, sections 62J.497, subdivisions 1, 3; 62J.84, subdivisions 6, 9; 144.0724, subdivision 4; 144.1481, subdivision 1; 144.1501, subdivisions 1, 2, 3; 144.551, subdivision 1; 144.9501, subdivision 17; 148B.5301, subdivision 2; 151.335; 151.72, subdivision 5; 152.27, subdivision 2; 152.29, subdivisions 1, 3; 256B.0371, subdivision 4; 256B.04, subdivision 14; 256B.0625, subdivisions 3b, 9, as amended, 13, 17, 30, 31; 256B.0631, subdivision 1, as amended; 256L.07, subdivision 1; 256L.15, subdivision 2; 363A.50; Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended; Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended; Laws 2021, First Special Session chapter 2, article 1, section 4, subdivision 2; Laws 2021, First Special Session chapter 7, article 1, section 36; article 3, section 44; article 16, section 2, subdivisions 29, 31, 33; article 17, sections 3; 6; 10; 11; 12; 17, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62Q; 62W; 115; 144; 144A; 145; 149A; 152; 256B; repealing Minnesota Statutes 2020, sections 150A.091, subdivisions 3, 15, 17; 256B.057, subdivision 7; 256B.063; 256B.69, subdivision 20; 501C.0408, subdivision 4; 501C.1206."